

10185

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Pk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Eighth Avenue		d. STREET ADDRESS 219 Eighth Avenue	
3. NAME OF DECEASED (Type or print) First ORUM S. Middle ADAMS Last		4. DATE OF DEATH Month 10 Day 13 Year 1957	
5. SEX M	6. COLOR OR RACE M	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/95
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY F M C	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry F.		14. MOTHER'S MAIDEN NAME Mary V. Sterling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenosarcoma of Duodenum 194.8 DUE TO Pancreas + Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22-27 , 19 53 , to Oct 13 , 19 57 , that I last saw the deceased alive on 10-63 , 19 57 , and that death occurred at 1 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis J. Glass MD		ADDRESS (Street, city or town, state) DATE SIGNED 320 Patapsco Ave Baltimore Oct 14 57	
PHYSICIAN'S NAME (Type) DR LOUIS J. G. GLASS		BALTO #25-MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 10/16/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Avenue		ADDRESS 130 E. Fort Avenue	
24a. REC'D BY REGISTRAR OCT 16 1957		24b. REGISTRAR'S SIGNATURE da M. H. Lee	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10146

10148

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S.N. Hospital, Annapolis, Md.		d. STREET ADDRESS 6 Kent Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Greene ATWOOD Jr.		4. DATE OF DEATH Month Day Year Oct 13 1957	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 July 1943
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Greene ATWOOD		14. MOTHER'S MAIDEN NAME Lois H. HILL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT U.S.N. Hospital, Annapolis, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CONFLUENT BRONCHOPNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STAPHYLOCOCCUS AUREUS DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH One week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Oct. , 1957 , to 13 Oct. , 1957 , that I last saw the deceased alive on 13 Oct. , 1957 , and that death occurred at 5:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S.N. Hospital, Annapolis, Md. 14 Oct 1957			
ACTUAL SIGNATURE Robert M. Taylor Lt MC USNR M.D. U.S.N. Hospital, Annapolis, Md. 14 Oct 1957			
PHYSICIAN'S NAME (Type) M. J. MILLER LT MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR 10/15/57	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE J. J. J. J.	

CERTIFICATE OF DEATH

Handwritten notes:
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

BUREAU V. S.

OCT 17 1957

RECEIVED

10149

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>A.A. Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Md.</i> b. COUNTY <i>A.A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Cell General Hosp.</i> | | d. STREET ADDRESS <i>1 Spa View Ave</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Caroline Bernstein</i> | | 4. DATE OF DEATH <i>10-9-1957</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-23-1899</i> |
| 9. AGE (In years last birthday) <i>77</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Caroline Müller</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | |
| 17. INFORMANT <i>John Bernstein</i> | | Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>
DUE TO <i>Arteriosclerotic Heart Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1 week</i>
(c) <i>1 yr.</i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cholecystitis acute with cholelithiasis</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Feb. 10, 1950</i> to <i>Oct. 9, 1957</i> , that I last saw the deceased alive on <i>10-9-1957</i> , and that death occurred at <i>9:55</i> M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <i>65 SHAW ST. ANNAPOLIS, MD</i>
DATE SIGNED <i>9-10-57</i> | | | |
| ACTUAL SIGNATURE <i>James R. Martin</i> M.D. | | PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>10-12-57</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i> | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Saylor</i> ADDRESS <i>Annapolis Md</i> | | 24a. REC'D BY REGISTRAR <i>10/11/57</i> | 24b. REGISTRAR'S SIGNATURE <i>J. D. French</i> |

CERTIFICATE OF DEATH

Form 10-1-14

BUREAU V. S.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10148

10-86

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3V01.4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | | | d. STREET ADDRESS
726 1/2 W. Saratoga Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Rosalie Middle Bethea Last Bethea | | | | 4. DATE OF DEATH
Month 10 Day 29 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/12/1900 | |
| 9. AGE (In years lost birthday)
57 yrs. | | IF UNDER 1 YEAR
Months 57 Days 57 Hours 57 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
South Carolina | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
None | | | | 16. SOCIAL SECURITY NO.
None | | | |
| 17. INFORMANT
Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suppurative Peritonitis
DUE TO (b) Gangrenous recto-vaginal fistula
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Old Hysterectomy | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, Paranoid Type | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. ft. 19
p. m. 11:58 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Crownsville, Md. | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from November 16, 1948 to October 29, 1957 , that I last saw the deceased alive on October 29, 1957 , and that death occurred at 11:58 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | | | DATE SIGNED 10/29/57 | | | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | | | ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 22b. DATE THEREOF
11/3/57 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's Co. Md | | | | 22d. LOCATION (City, town, or county) (State)
St. Mary's Co. Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. O. Wilson | | | | ADDRESS
1000 Brantley Ave | | | |
| 24a. REC'D BY REGISTRAR
DATE 10/31/57 | | | | 24b. REGISTRAR'S SIGNATURE
J. M. Pryor | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

2007 7 NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10187 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY AA MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY A.A. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Linthicum | | c. LENGTH OF STAY IN 1b
31 yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Linthicum | | d. STREET ADDRESS
603 E. Maple Rd | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
603 E. Maple Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Carrie Middle May Last Biernan | | 4. DATE OF DEATH
Month Oct Day 19 Year 1957 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan 24 1868 |
| 9. AGE (In years last birthday)
89 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Alexandria Va | | 12. CITIZEN OF WHAT COUNTRY?
— | |
| 13. FATHER'S NAME
James R. Cole | | 14. MOTHER'S MAIDEN NAME
Melisa Walker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Albert Biernan | | Address
(Same) Son | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Vascular Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
8-10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1938 to 10/19 , 19 57 , that I last saw the deceased alive on 10/19/57 , 19 57 , and that death occurred at 11:15 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Chas. L. Ball | | DATE SIGNED
10/19/57 | |
| PHYSICIAN'S NAME (Type)
Linthicum Md | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 22/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Western | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Witzke Funeral Director, 4101 Edmondson Ave | | 24a. REC'D BY REGISTRAR
DATE OCT 22 1957 | |
| 24b. REGISTRAR'S SIGNATURE
A. H. Hedrick | | | |

CERTIFICATE OF DEATH

State of Maryland

BUREAU V. S.

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10150

10188

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | | | c. LENGTH OF STAY IN 1b
3 mos. 5 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | | | d. STREET ADDRESS
9 Mace's Lane | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle David Last Bishop | | | | 4. DATE OF DEATH
Month 10 Day 3 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/28/1888 | | 9. AGE (In years last birthday) yrs.
69 | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Ollie Bishop | | | | 14. MOTHER'S MAIDEN NAME
Hester | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
----- | | 17. INFORMANT
Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
443X IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease
DUE TO (c) Generalized Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Paraplegia amaurosis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m. ----- 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 28 , 19 57 , to October 3 , 19 57 , that I last saw the deceased alive on October 3 , 19 57 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | ADDRESS (Street, city or town, state)
Crownsville, Md. | | DATE SIGNED
10/3/57 | |
| PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | | | Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
10/8/57 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
Madison Cemetery | | 22d. LOCATION (City, town, or county) (State)
Dorchester Co. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. M. H. Clancy | | | | ADDRESS
317 High Street | | 24a. REC'D BY REGISTRAR
11 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
A. M. Joyce | | | |

CERTIFICATE OF DEATH

10788

| | | | | | |
|-------------------------------|--|---------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. DATE OF BIRTH | | 6. PLACE OF DEATH | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. DATE OF DEATH | | 11. TIME OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | |
| 19. SIGNATURE OF SHERIFF | | 20. SIGNATURE OF DEPUTY SHERIFF | | 21. SIGNATURE OF CONSTABLE | |
| 22. SIGNATURE OF TOWN CLERK | | 23. SIGNATURE OF TOWN ENGINEER | | 24. SIGNATURE OF TOWN CHURCH | |
| 25. SIGNATURE OF TOWN SCHOOL | | 26. SIGNATURE OF TOWN CHURCH | | 27. SIGNATURE OF TOWN SCHOOL | |
| 28. SIGNATURE OF TOWN CHURCH | | 29. SIGNATURE OF TOWN SCHOOL | | 30. SIGNATURE OF TOWN CHURCH | |
| 31. SIGNATURE OF TOWN SCHOOL | | 32. SIGNATURE OF TOWN CHURCH | | 33. SIGNATURE OF TOWN SCHOOL | |
| 34. SIGNATURE OF TOWN CHURCH | | 35. SIGNATURE OF TOWN SCHOOL | | 36. SIGNATURE OF TOWN CHURCH | |
| 37. SIGNATURE OF TOWN SCHOOL | | 38. SIGNATURE OF TOWN CHURCH | | 39. SIGNATURE OF TOWN SCHOOL | |
| 40. SIGNATURE OF TOWN CHURCH | | 41. SIGNATURE OF TOWN SCHOOL | | 42. SIGNATURE OF TOWN CHURCH | |
| 43. SIGNATURE OF TOWN SCHOOL | | 44. SIGNATURE OF TOWN CHURCH | | 45. SIGNATURE OF TOWN SCHOOL | |
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| 49. SIGNATURE OF TOWN SCHOOL | | 50. SIGNATURE OF TOWN CHURCH | | 51. SIGNATURE OF TOWN SCHOOL | |
| 52. SIGNATURE OF TOWN CHURCH | | 53. SIGNATURE OF TOWN SCHOOL | | 54. SIGNATURE OF TOWN CHURCH | |
| 55. SIGNATURE OF TOWN SCHOOL | | 56. SIGNATURE OF TOWN CHURCH | | 57. SIGNATURE OF TOWN SCHOOL | |
| 58. SIGNATURE OF TOWN CHURCH | | 59. SIGNATURE OF TOWN SCHOOL | | 60. SIGNATURE OF TOWN CHURCH | |
| 61. SIGNATURE OF TOWN SCHOOL | | 62. SIGNATURE OF TOWN CHURCH | | 63. SIGNATURE OF TOWN SCHOOL | |
| 64. SIGNATURE OF TOWN CHURCH | | 65. SIGNATURE OF TOWN SCHOOL | | 66. SIGNATURE OF TOWN CHURCH | |
| 67. SIGNATURE OF TOWN SCHOOL | | 68. SIGNATURE OF TOWN CHURCH | | 69. SIGNATURE OF TOWN SCHOOL | |
| 70. SIGNATURE OF TOWN CHURCH | | 71. SIGNATURE OF TOWN SCHOOL | | 72. SIGNATURE OF TOWN CHURCH | |
| 73. SIGNATURE OF TOWN SCHOOL | | 74. SIGNATURE OF TOWN CHURCH | | 75. SIGNATURE OF TOWN SCHOOL | |
| 76. SIGNATURE OF TOWN CHURCH | | 77. SIGNATURE OF TOWN SCHOOL | | 78. SIGNATURE OF TOWN CHURCH | |
| 79. SIGNATURE OF TOWN SCHOOL | | 80. SIGNATURE OF TOWN CHURCH | | 81. SIGNATURE OF TOWN SCHOOL | |
| 82. SIGNATURE OF TOWN CHURCH | | 83. SIGNATURE OF TOWN SCHOOL | | 84. SIGNATURE OF TOWN CHURCH | |
| 85. SIGNATURE OF TOWN SCHOOL | | 86. SIGNATURE OF TOWN CHURCH | | 87. SIGNATURE OF TOWN SCHOOL | |
| 88. SIGNATURE OF TOWN CHURCH | | 89. SIGNATURE OF TOWN SCHOOL | | 90. SIGNATURE OF TOWN CHURCH | |
| 91. SIGNATURE OF TOWN SCHOOL | | 92. SIGNATURE OF TOWN CHURCH | | 93. SIGNATURE OF TOWN SCHOOL | |
| 94. SIGNATURE OF TOWN CHURCH | | 95. SIGNATURE OF TOWN SCHOOL | | 96. SIGNATURE OF TOWN CHURCH | |
| 97. SIGNATURE OF TOWN SCHOOL | | 98. SIGNATURE OF TOWN CHURCH | | 99. SIGNATURE OF TOWN SCHOOL | |
| 100. SIGNATURE OF TOWN CHURCH | | 101. SIGNATURE OF TOWN SCHOOL | | 102. SIGNATURE OF TOWN CHURCH | |

RECEIVED
OCT 11 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10151

Reg. Dist. No. 24

| | | | | | |
|--|------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Same</u> b. COUNTY <u>Same</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pasadena</u> | | c. LENGTH OF STAY IN 1b
<u>All life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Same</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Old Jumper Hole Rd.</u> | | | d. STREET ADDRESS
<u>Same</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
<u>Edward A. Bolm</u> | | | 4. DATE OF DEATH
Month <u>October</u> Day <u>16th</u> Year <u>1957</u> | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/31/06</u> | | 9. AGE (in years last birthday)
<u>51</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Pasadena, M.d.</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Carl Bolm</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Eleanore Meyers</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | 17. INFORMANT Address
<u>Mr. Georges Bolm (brother) Pasadena, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u>
DUE TO (c) <u></u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/16/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/18/57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore 25, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Hopping & Kirkley, Glen Burnie, Md.</u> | | | 24a. REC'D BY REGISTRAR
<u>OCT 21 1957</u> | | 24b. REGISTRAR'S SIGNATURE
<u>L. J. Adell</u> |

MEDICAL CERTIFICATION

RECEIVED

OCT 21 1957

BUREAU V. S.

15

10150

CERTIFICATE OF DEATH

Reg. Dist. No.

21

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 day</u>
<u>20 Gambrills</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BOSCHERT</u> Last <u>BOSCHERT</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec 18, 1888</u> | |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Henry Pante</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gertrude (unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mr. Adam J. Boschert Same as Fm</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE</u>
DUE TO (b) <u>RUPTURED ANEURYSM OF BASILAR</u>
DUE TO (c) <u>ARTERY</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>330X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INDETERMINATE</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <u>11</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>10/1</u> , 19 <u>57</u> , to <u>10/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/2</u> , 19 <u>57</u> , and that death occurred at <u>12:58 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Richard N. Peeler</u> | | | | ADDRESS (Street, city or town, state) <u>68 Franklin St. Annapolis, Md.</u> | | | |
| DATE SIGNED <u>10/2/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 2, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field Ch. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Millersville Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Burnie, Md.</u> | | | | ADDRESS <u>Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR <u>Mr. J. French</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | | DATE <u>Oct 8 1957</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

152

BUREAU V. S.

1957 8 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10153

10190 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
24 yrs, 6 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
10 Crownsville State Hospital, Md. | | d. STREET ADDRESS
544 St. Mary's | |
| 3. NAME OF DECEASED (Type or print)
First Vina Middle Brooks Last Brooks | | 4. DATE OF DEATH
Month 10 Day 8 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Unknown |
| 9. AGE (In years last birthday)
54 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Basil Brooks | | 14. MOTHER'S MAIDEN NAME
Mary | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NO | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
570.5
IMMEDIATE CAUSE (a) Peritonitis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Partial Intestinal Obstruction
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Mental Deficiency - Imbecile | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/8/1933 to 10/8/1957 , that I last saw the deceased alive on 10/8/1957 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/8/57
ACTUAL SIGNATURE Lionel McHenry Mapp
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
10-10-57 | | 22b. DATE THEREOF
10-10-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
W. F. M. M. School | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William H. H. #108 Wash St. Annapolis | | 24a. REC'D BY REGISTRAR
14 1957 | |
| 24b. REGISTRAR'S SIGNATURE
A. M. Jones | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

OCT 15 1961

RECEIVED

10191

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
20 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Lester Middle Brown Last Brown | | 4. DATE OF DEATH
Month 10 Day 7 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/16/16 |
| 9. AGE (In years last birthday)
41 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Noah Henry Brown | | 14. MOTHER'S MAIDEN NAME
Fannie Finney | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
----- | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hyperthyroid Condition
DUE TO
(c) ----- | | | INTERVAL BETWEEN ONSET AND DEATH
8 hrs.

since admission
9/17/57 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Involuntional Psychosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. ----- p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State)
----- | |
| 21. I certify that I attended the deceased from 9/17/57 , 19 57 , to 10/7 , 19 57 , that I last saw the deceased alive on 10/7 , 19 57 , and that death occurred on 8:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>Lionel McHenry Mapp</i> | | ADDRESS (Street, city or town, state)
Crownsville, Md. | |
| PHYSICIAN'S NAME (Type)
Lionel McHenry Mapp, M. D. | | DATE SIGNED
10/7/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/13/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Mary | | 22d. LOCATION (City, town, or county) (State)
West Pot office Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>William H. James</i> | | 24. REC'D BY REGISTRAR
15 1957 | |
| ADDRESS
<i>James</i> | | 24b. REGISTRAR'S SIGNATURE
<i>A. M. Joyce</i> | |

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | |
| DATE OF BIRTH | | PLACE OF BIRTH | | CITY | |
| OCCUPATION | | EDUCATION | | RELIGION | |
| MANNER OF DEATH | | CAUSE OF DEATH | | DISEASE | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |

BUREAU V. 3

OCT 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10192

CERTIFICATE OF DEATH

10155

Reg. Dist. No. 24

| | | | |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Annie Arundle MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenburnie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Plaza Manor Nursing Home | | d. STREET ADDRESS
2128 N. Pulaski Street | |
| 3. NAME OF DECEASED (Type or print)
First MINNIE Middle Last CALVERY | | 4. DATE OF DEATH
Month October Day 23 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 16, 1882 |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 11. BIRTHPLACE (State or foreign country)
Virginia; Lancaster Co. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Weinburg | | 14. MOTHER'S MAIDEN NAME
Lettie Mitchell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Ernestine Williams | | Address
247 N. Kentucky Avenue
Atlantic City, New Jersey | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma Lungs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Crcinoma Uterus
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
?
? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 20, 1957 , to October 23, 1957 , that I last saw the deceased alive on October 20, 1957 , and that death occurred at 4 A. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
James M. Pair, M.D. 400 N. Carrollton Avenue
Baltimore 23, Maryland | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 26, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Mays Landing, New Jersey | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Elroy O. Wilson | | ADDRESS
1000 Brantley Avenue | |
| 24a. REC'D BY REGISTRAR
10/29/57 | | 24b. REGISTRAR'S SIGNATURE
L. J. Dealy | |

RECEIVED
OCT 30 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10193 CERTIFICATE OF DEATH

10156

Reg. Dist. No. 48

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
1yr, 7mo, 3ds. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | d. STREET ADDRESS
05 x 0.2 | |
| 3. NAME OF DECEASED (Type or print)
First Ella Middle Carney Last Carney | | 4. DATE OF DEATH
Month 10 Day 30 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Unknown |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
Hospital Records | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis
DUE TO (c) since admission | | INTERVAL BETWEEN ONSET AND DEATH
10/28/57 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome associated with Arteriosclerosis | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. s. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/27/56 , 19 56 , to October 30 , 19 57 , that I last saw the deceased alive on October 30 , 19 57 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/30/57 | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Buried | | 22b. DATE THEREOF
Nov. 4, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Brentwood Md | | 22d. LOCATION (City, town, or county) (State)
Brentwood Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond B. Paulk | | 24a. REC'D BY REGISTRAR
DATE 11/4/57 | |
| ADDRESS
Brentwood Md | | 24b. REGISTRAR'S SIGNATURE
L. M. Pippin
L. M. Pippin | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10157

10194 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Davidsonville | | c. LENGTH OF STAY IN 1b
Davidsonville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print) LAURA P. DAWSON CARR | | 4. DATE OF DEATH
Month OCTOBER Day 15 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 26, 1877 |
| 9. AGE (In years last birthday)
79 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (State or foreign country)
Mayo, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Nicholas G. Collison | | 14. MOTHER'S MAIDEN NAME
Susan Hubbard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs Alvin Owens- Daughter- same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of colon
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 55 , to Oct. 15 , 19 57 , that I last saw the deceased alive on Oct. 15 , 19 57 , and that death occurred at 7 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Emily H. Wilson | | DATE SIGNED 10-18-57 | |
| PHYSICIAN'S NAME (Type) Emily H. Wilson MD | | ADDRESS (Street, city or town, state) Harwood, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
October 18, 57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mayo Memorial Cemet. | | 22d. LOCATION (City, town, or county) (State)
Mayo, Maryland (A.A. County) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | 24a. REC'D BY REGISTRAR
SET 21 '57 | |
| ADDRESS
Annapolis, Md. | | 24b. REGISTRAR'S SIGNATURE
W. H. H. H. | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1951

BUREAU V. 3

OCT 21 1957

RECEIVED

| | | | |
|------------------|--|----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES H. HARRIS | | OCTOBER 18, 1957 | |
| AGE | | SEX | |
| 68 | | Male | |
| RACE | | COLOR | |
| White | | White | |
| BIRTH DATE | | BIRTH PLACE | |
| JANUARY 1, 1889 | | BALTIMORE, MARYLAND | |
| MARRIAGE DATE | | MARRIAGE PLACE | |
| JANUARY 1, 1910 | | BALTIMORE, MARYLAND | |
| OCCUPATION | | CAUSE OF DEATH | |
| Retired | | Heart Disease | |
| PLACE OF DEATH | | MANNER OF DEATH | |
| Home | | Natural | |
| CITY | | COUNTY | |
| BALTIMORE | | BALTIMORE | |
| STATE | | FEDERAL DISTRICT | |
| MARYLAND | | DISTRICT OF COLUMBIA | |
| ZIP CODE | | CENSUS TRACT | |
| 21201 | | 100 | |

10195 CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Plaza Manor Nursing Home | | | | e. STREET ADDRESS
620 N. Monroe Street | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Louise Last Carter | | | | 4. DATE OF DEATH
Month October Day 30 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 10, 1907 | |
| 9. AGE (In years last birthday)
50 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Heathsville, Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Allen Young | | | | 14. MOTHER'S MAIDEN NAME
Alverta Young | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
(If yes, give year or dates of service) | | 17. INFORMANT
Pauline Haywood Address 620 N. Monroe Street | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident, Left hemiparesis
443x DUE TO
(b) Hypertensive Arteriosclerotic Cardiovascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Disease with decompensation and Auricular
(c) Fibrillation.
INTERVAL BETWEEN ONSET AND DEATH 6 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from October 23 1957 to October 30 1957 , that I last saw the deceased alive on October 28 1957 , and that death occurred at 9: A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 400 N. Carrollton Avenue DATE SIGNED 10.31.57
ACTUAL SIGNATURE James M. Pair M.D.
PHYSICIAN'S NAME (Type) James M. Pair, M.D. Baltimore 23, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 3, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Edwardsville | | 22d. LOCATION (City, town, or county) (State)
Edwardsville, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles R. Law | | | | ADDRESS
802 Madison Avenue | | 24. REGISTRAR'S SIGNATURE
Louis DeAlba | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 3 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G222 11-6-57 et

10159

Reg. Dist. No.

| | | | | | |
|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jacobsville | | | c. LENGTH OF STAY IN 1b
Baltimore 3 vol-4 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Route 607 - Hogneck Road. | | | d. STREET ADDRESS
161 W. Henrietta Street | | |
| 3. NAME OF DECEASED (Type or print)
First O'NEIL Middle Last CARTER | | | 4. DATE OF DEATH
Month October Day 20 Year 19 57 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 15, 1923 | | 9. AGE (In years last birthday)
34 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
L | | | 10b. KIND OF BUSINESS OR INDUSTRY
S.C. | | 11. BIRTHPLACE (State or foreign country)
S.C. |
| 13. FATHER'S NAME
Sam Carter | | | 14. MOTHER'S MAIDEN NAME
Katie Bennett | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Traumatic Injuries.
812X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
Pedestrian struck by auto. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Pedestrian struck by auto. | | |
| 20c. TIME OF INJURY
Month, Day, Year
11:25 Hour 20 p. m. 10/20 19 57 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Highway | | | 20f. (City or town) (County) (State)
Jacobsville A.A. Md. | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Paul F. Guerin | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type)
Paul F. Guerin, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED
10/21/57 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-26-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt Auburn Cemtery | |
| 22d. LOCATION (City, town, or county)
Baltimore, Md. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Isaiah L. Brown and Son ADDRESS 108 W. Montgomery St | | | | | |
| 24a. REC'D BY REGISTRAR
Oct 31 1957 | | | | | |
| 24b. REGISTRAR'S SIGNATURE
Louis J. DeAlba | | | | | |

ET

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10160

10151

Reg. Dist. No.

31

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|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ANNAPOLIS</u> | | c. LENGTH OF STAY IN 1b
<u>50 minutes</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X2 EDGEWATER Washington D.C.</u> | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>ANNE ARUNDEL GENERAL</u> | | | | d. STREET ADDRESS <u>1321 Constitution Ave NE</u>
<u>1 BOX 282 Rt. 3</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>LESLIE</u> <u>CICALA</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>OCT.</u> <u>20</u> <u>1957</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Mar. 24, 1921</u> | |
| 9. AGE (In years last birthday)
<u>36</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SHOEMAKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self Employed</u> | | 11. BIRTHPLACE (State or foreign country)
<u>ITALY Sicily</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>DOMENICO CICALA</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>GIOVANNA ROSCONA</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY NO.
<u>578-12-2779</u> | | 17. INFORMANT
<u>MRS. JEAN CICALA</u> Address <u>1321 Const. Ave Edgewater Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MASSIVE HEMOTHORAX</u>
<u>825x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>FRACTURES OF RIBS</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 20 min.</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>AUTO ACCIDENT</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>11</u> a.m. <u>10/19/57</u>
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Route 214 nr Davidsonville, A.A. Md.</u> | | 20f. (City or town) (County) (State)
<u>Davidsonville, A.A. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<u>Jesse L. Wilkins, M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
<u>JESSE L. WILKINS, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct. 24, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Switzland, Maryland.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chambers</u> | | | | ADDRESS <u>Wash., D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>Mr. J. French</u> | |
| | | | | DATE
<u>OCT 22 1957</u> | | 24b. REGISTRAR'S SIGNATURE | |

INVESTIGATE DEPARTMENT OF HEALTH - DIVISION 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10197 CERTIFICATE OF DEATH

10161

Reg. Dist. No. 24

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|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>anne Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i> | | c. LENGTH OF STAY IN TB <i>4 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3 Amelia Ave (N.E)</i> | | d. STREET ADDRESS <i>1 3 Amelia Ave</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>DAISY</i> Middle <i>MAY</i> Last <i>CLARK</i> | | 4. DATE OF DEATH
Month <i>OCT.</i> Day <i>4</i> Year <i>1957</i> | |
| 5. SEX <i>F.</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9 Sept 1902</i> |
| 9. AGE (In years last birthday) <i>55</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>KENTUCKY</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>yes-US.</i> | |
| 13. FATHER'S NAME <i>ANDREW MOORE (dec.)</i> | | 14. MOTHER'S MAIDEN NAME <i>NANCY NOBLE (dec.)</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <i>403-18-6151</i> | |
| 17. INFORMANT Address <i>5 Amelia Ave. Glen Burnie, Md.</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute myocarditis</i>
174X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer of uterus</i>
DUE TO (c) <i>Generalized carcinomatosis</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension - 5 yrs.</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>2 yrs</i>
<i>4 mos.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>none</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <i>3</i> p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> or work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glen Burnie, A. Arundel, Md.</i> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May</i> , 1955, to <i>4 Oct</i> , 1957, that I last saw the deceased alive on <i>28 Sept</i> , 1957, and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Hubert F. Manuzak</i> M.D. | | ADDRESS (Street, city or town, state) <i>901 EDGERLY RD.</i> DATE SIGNED <i>4 Oct. 1957</i> | |
| PHYSICIAN'S NAME (Type) <i>HUBERT F. MANUZAK</i> | | <i>GLEN BURNIE, MD.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 22b. DATE THEREOF <i>Oct. 7-1957</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R. S. Sington</i> ADDRESS <i>Glen Burnie, Md.</i> | | 24a. REC'D BY REGISTRAR <i>DATE 8 1957</i> | 24b. REGISTRAR'S SIGNATURE <i>L. J. Sedgwick</i> |

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10188

Item 72 Film G221, 10/10/57 fcy

CERTIFICATE OF DEATH

Reg. Dist. No.

21

| | | | |
|---|------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Anne Arundel</i> <i>Gen Hosp</i>
<i>Annapolis - Maryland</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY <i>Anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | | c. LENGTH OF STAY IN 1b
<i>10 Annapolis</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Anne Arundel Gen Hosp</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
KNOWN AS: <i>ELISIE CLARK</i>
<i>LYNN GIGUERE</i> | | 4. DATE OF DEATH
Month <i>10</i> Day <i>2</i> Year <i>1957</i> | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<i>10-19-32</i> |
| 9. AGE (In years last birthday)
<i>26</i> yrs. | | IF UNDER 1 YEAR: Months <i>26</i> Days <i>26</i> Hours <i>26</i> Min. <i>26</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Waitress</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>214-26-0624</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Md</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>Delmar Clark</i> | | 14. MOTHER'S MAIDEN NAME
<i>Elsie A. Fugate</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Hospital Records</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Phosphorus Poisoning</i>
<i>971.8</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Suicide intent by phosphorus ingestion</i>
DUE TO (c) <i>8 days</i>
<i>8 days</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>8 days</i>
<i>8 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Sept 24</i> , 19 <i>57</i> , to <i>Oct 2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 2</i> , 19 <i>57</i> , and that death occurred at <i>1:14 A.M.</i> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE
<i>Richard N. Peeler</i> | | M.D. | |
| PHYSICIAN'S NAME (Type)
<i>RICHARD N. PEELER</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>Oct. 5, 1957</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>LILLY + ZEILER, INC. 1901 EASTERN AVE</i> | | 24a. REC'D BY REGISTRAR
<i>OCT 7 1957</i> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE
<i>Mr. J. French</i> | |

CERTIFICATE OF DEATH

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|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
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Do not issue ~~any~~ copies of this certificate.

Request made by Mrs. Elsie A. Clark

2103 E. Lamley St.

Baltimore 31, Md.

*Copy to
mother 11/4*

mother of deceased.

11/1/57 cac

copy of this certificate
sent to the State A. Clerk
John T. Lantry
Baltimore 21, Md.

noted at present.

W. W. Lee

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10162

10198

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
5 yrs.4mos.11 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Skidmore, Md. | | x2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | d. STREET ADDRESS
R. F. D. 2, Box 557 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Arie Middle Colbert Last Colbert | | 4. DATE OF DEATH
Month 10 Day 9 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/14/01 |
| 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months 5 Days 10 Hours 19 Min. | IF UNDER 24 HRS.
Months 5 Days 10 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Eligah Henson | | 14. MOTHER'S MAIDEN NAME
Gertrude Cook | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NO | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emaciation
286.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Malnutrition DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from May 28 , 19 52 , to October 9 , 19 57 , that I last saw the deceased alive on October 9 , 19 57 , and that death occurred at 9:26a. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/10/57
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-13-57 | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn | 22d. LOCATION (City, town, or county) (State)
Skidmore Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William R. Rector | | 24a. REC'D BY REGISTRAR
10/14/57 | |
| ADDRESS
108 Wash. St. Annapolis | | 24b. REGISTRAR'S SIGNATURE
R. M. Joyce | |

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------|--|--------------------------|--|-----------------------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | | PLACE OF BIRTH | |
| SEX | | RACE | | EDUCATION | |
| MARRIAGE | | OCCUPATION | | CAUSE OF DEATH | |
| DATE OF DEATH | | PLACE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | |
| SIGNATURE OF MINISTER | | SIGNATURE OF CORONER | | SIGNATURE OF JUDGE | |
| SIGNATURE OF CLERK | | SIGNATURE OF SHERIFF | | SIGNATURE OF TOWNSHIP CLERK | |
| SIGNATURE OF COUNTY CLERK | | SIGNATURE OF STATE CLERK | | SIGNATURE OF U.S. DEPT. OF HEALTH | |

BUREAU V. S.

OCT 15 1957

RECEIVED

Handwritten signature and notes at the bottom of the form.

10153

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>A. A. County</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Riva</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>146 Besgate Rd.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>John J. Colbert</i> | | 4. DATE OF DEATH <i>10-1-1957</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-7-1957</i> |
| 9. AGE (In years last birthday) <i>4</i> | | 10. IF UNDER 1 YEAR <i>4</i> Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Riva, Md. (See Birth Cert.)</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Clasiah Colbert</i> | | 14. MOTHER'S MAIDEN NAME <i>Shirley Griffith</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Shirley Colbert</i> | | Address <i>146 Besgate Rd.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i>
<i>491X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>C Malnutrition & Dehydration & Quinlan</i> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>13 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10/1/57</i> , 19____, to _____, 19____, that I last saw the deceased alive on <i>10/1/57</i> , 19____, and that death occurred at <i>11 A.</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Theodore N. Johnson M.D.</i> | | ADDRESS (Street, city or town, state) <i>37 Leakes Street</i> | |
| PHYSICIAN'S NAME (Type) <i>Dr. THEODORE H. JOHNSON</i> | | DATE SIGNED <i>Annapolis, Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>10-3-57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hall</i> | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Prescott</i> | | ADDRESS <i>108 Wash. St.</i> | |
| 24a. REC'D BY REGISTRAR <i>OCT 3 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4100182XV4

27

CERTIFICATE OF DEATH

STATE OF NEW YORK - ALBANY

NO. 101

| | | | |
|---|--|---|--|
| NAME OF DECEASED
<i>John Doe</i> | | DATE OF BIRTH
<i>Jan 1, 1900</i> | PLACE OF BIRTH
<i>New York City</i> |
| RESIDENCE
<i>123 Main St, New York City</i> | | DATE OF DEATH
<i>Oct 2, 1957</i> | PLACE OF DEATH
<i>New York City</i> |
| CAUSE OF DEATH
<i>Heart Disease</i> | | MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | |
| SEX
<i>Male</i> | | RACE
<i>White</i> | |
| EDUCATION
<i>High School</i> | | OCCUPATION
<i>Teacher</i> | |
| MARRIAGE
<i>Married</i> | | SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | |
| NAME OF SPOUSE
<i>Jane Doe</i> | | DATE OF MARRIAGE
<i>Jan 1, 1920</i> | |
| NAME OF CHILDREN
<i>John Jr., Jane, Robert</i> | | DATE OF BIRTH OF CHILDREN
<i>1925, 1928, 1930</i> | |
| NAME OF PHYSICIAN
<i>Dr. Smith</i> | | NAME OF FUNERAL HOME
<i>ABC Funeral Home</i> | |
| NAME OF MINISTER
<i>Rev. Brown</i> | | NAME OF BURIAL PLACE
<i>St. Mary's Cemetery</i> | |
| NAME OF CORONER
<i>John Doe</i> | | NAME OF JURY
<i>John Doe, Jane Doe, Robert Doe</i> | |
| NAME OF JURY
<i>John Doe, Jane Doe, Robert Doe</i> | | NAME OF JURY
<i>John Doe, Jane Doe, Robert Doe</i> | |

BUREAU V. S.

OCT 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10153

Item 2 Film G221 10-10-57 et

CERTIFICATE OF DEATH

10164

Reg. Dist. No.

| | | | |
|---|---------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>A. A. County</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. STREET ADDRESS
<i>146 Bestgate Rd.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Shirley ann Colbert</i> | | 4. DATE OF DEATH
Month <i>10</i> Day <i>1</i> Year <i>1957</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-7-1957</i> |
| 9. AGE (In years last birthday) <i>4</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months <i>4</i> Days <i>1</i> Hours <i>1</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Riva, Md. (See: Birth Cert. M.S.A.)</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Ossiah Colbert</i> | | 14. MOTHER'S MAIDEN NAME <i>Shirley Griffith</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Shirley Colbert</i> | | Address <i>146 Bestgate Rd.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bacterial Pneumonia</i>
<i>491 X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>E. Malmström & Delphat & Pancher</i> DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH <i>13 day.</i>
<i>13 day</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10/1/57</i> , 19 <i>57</i> , to <i>10/1/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>10/1/57</i> , 19 <i>57</i> , and that death occurred at <i>12:00 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Theodore H. Johnson</i> M.D. | | ADDRESS (Street, city or town, state) <i>37 Calvert St. Annapolis, Md.</i> | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <i>Dr. THEODORE H. JOHNSON</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>10-3-1957</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hall</i> | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Prescott</i> | | ADDRESS <i>108 Wash. Street</i> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i> | |
| DATE | | | |

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ET

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Part B - Burial

DATE OF DEATH

PLACE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

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BUREAU V. 2

OCT 3 1957

RECEIVED

10154

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u> 10 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u> | | d. STREET ADDRESS <u>10 MUNROE COURT</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR W. CONDELL</u> | | 4. DATE OF DEATH Month Day Year <u>10 1 1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-23-1896</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD RET.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY SERVICE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>CHICAGO, ILL.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>ARTHUR CONDELL</u> | | 14. MOTHER'S MAIDEN NAME <u>"UNK."</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1913-1924</u> | | 16. SOCIAL SECURITY NO. <u>ESTHER CONDELL #2</u> | |
| 17. INFORMANT Address <u>ESTHER CONDELL #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u>
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>10-1-</u> , 19 <u>57</u> , to <u>10-1-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-1-</u> , 19 <u>57</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>6 SHAW ANNAPOHIS, MD</u>
DATE SIGNED <u>10/3/57</u> | | | |
| ACTUAL SIGNATURE <u>James R. Martin</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>10-4-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLVD #</u> | 22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>10/4/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. D. Dunch</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BACILLI ONE 18
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

BUREAU V. 8

OCT 7 1957

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BACILLI ONE 18
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 10199 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Item 8 - See Birth Certificate, Item 20 Film 222 11-15-57 am Reg. Dist. No. 21 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY AA.CO. | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - Annapolis | | c. LENGTH OF STAY IN 1b
2 MONS. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD | | b. COUNTY AA.CO | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | d. STREET ADDRESS
141 ST. MARGARETS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) | | First Dino | | Middle | | Last Cook | | 4. DATE OF DEATH
Month 10 Day 22 Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 2, 1957 | | 9. AGE (In years last birthday)
2 MONS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (State or foreign country)
St. Margarets | | IF UNDER 1 YEAR
Months <input checked="" type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 13. FATHER'S NAME
Alfred Lee Johnson | | | | 14. MOTHER'S MAIDEN NAME
Grace Cook | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Blacks Cook Address St. Margarets | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration Vomitus
921.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Aspirated vomitus while feeding on bottle | | | | | | | |
| 20c. TIME OF INJURY
Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town)
St. Margarets | | 20g. (County)
AA | | | |
| 20h. (State)
Md | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
E. L. Linhart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
10/24/57 | | | | | |
| EXAMINER'S NAME (Type)
E. L. Linhart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
Oct 24 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Broadway | | 22d. LOCATION (City, town, or county)
St. Margarets Md | | 22e. (State)
Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arnold C. Johnson | | | | ADDRESS
Annapolis | | 24a. REC'D BY REGISTRAR
Dr. W. J. French | | 24b. REGISTRAR'S SIGNATURE
Dr. W. J. French | | | |
| 24c. DATE
OCT 24 1957 | | | | | | | | | | | |

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RECEIVED

OCT 24 1957

BUREAU V. S.

10200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3, Film G224, 1/21/58 icy

Reg. Dist. No. 24

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|-----------------------|---|-----------------------------|--|--|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Same | | b. COUNTY Same | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
P.O. Pasadena | | c. LENGTH OF STAY IN 1b
10 y. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Same x2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Poplar Ridge | | | | d. STREET ADDRESS
Same | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Hilda May Cooke | | | | 4. DATE OF DEATH
October 20th. 19 57 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/14/11 | | 9. AGE (in years last birthday)
46 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John P. Lottier | | | | 14. MOTHER'S MAIDEN NAME
Carrie M. Waterman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. John E. Cooke (husband) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio vascular diseases
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Gustave H. Faubert, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
Gustave H. Faubert, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/22/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-23-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Glen Haven | | 22d. LOCATION (City, town, or county) (State)
Glen Burnie, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Singleton Funeral Home, Glen Burnie, Md. | | | | 24a. REC'D BY REGISTRAR
OCT 24 1957 | | 24b. REGISTRAR'S SIGNATURE
Louis J. DeAlba | |

RECEIVED

OCT 24 1957

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10155

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10168

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSP.</u> | | d. STREET ADDRESS <u>1406 SEVERN AVE.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>NEVA</u> Middle <u>KENT</u> Last <u>CRONIN</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-6-1882</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ETHERIDGE KENT</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ANN CHANCE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>75</u> | |
| 17. INFORMANT <u>Julia Kent</u> | | Address <u># 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture Hip Left</u>
9040 DUE TO <u>Pneumonia Hypostatic</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>16 days</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bath room</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>10/6 1957</u>
Hour <u>10</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Annapolis</u> (County) <u>MD.</u> (State) <u>MD.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10-24-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u> | | 22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Roberts & Sons</u> | | 24a. REC'D BY REGISTRAR <u>10/24/57</u> | |
| ADDRESS <u>Annapolis, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

BUREAU V. S.

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10201

CERTIFICATE OF DEATH

Reg. Dist. No.

10169

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | | | c. LENGTH OF STAY IN 1b
4 ys. 10 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
10 Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | | | d. STREET ADDRESS
20 Water Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Pearl Middle Curry Last Curry | | | | 4. DATE OF DEATH
Month 10 Day 17 Year 19 57 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/2/27 | |
| 9. AGE (In years last birthday)
30 yrs. | | IF UNDER 1 YEAR
Months 10 Days 17 Hours 19 Min. | | IF UNDER 24 HRS.
Months 10 Days 17 Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dishwasher | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
William Curry | | | | 14. MOTHER'S MAIDEN NAME
Mamie | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
----- | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia - Bilateral Lobar
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 490x
DUE TO (c) ----- | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. ----- p. m. ----- 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 21, 19 52 , to October 17, 19 57 , that I last saw the deceased alive on October 17, 19 57 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | | | ADDRESS (Street, city or town, state)
Crownsville, Md. | | DATE SIGNED
10/17/57 | |
| PHYSICIAN'S NAME (Type)
Lionel McHenry Mapp, M. D. | | | | Crownsville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-21-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Brewer Hill | | 22d. LOCATION (City, town, or county) (State)
Annapolis Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Reese, Jr. - Anne. Md. | | | | ADDRESS
----- | | 24a. REC'D BY REGISTRAR
DATE 10/22/57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
St. M. Joyce | |

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The form is mostly blank with some faint markings.

BUREAU V. S.

OCT 28 1957

RECEIVED

10-21-57
J. M. Green, Jr. - Clerk

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Item 9, Film G221, 10/24/57 fcy

10170

CERTIFICATE OF DEATH

10202

Reg. Dist. No. 24

| | | | | | | | |
|--|------------------------------|--|--|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH
COUNTY <u>ANNE ARUNDEL</u> MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> LENGTH OF STAY (in this place)
TOWN <u>PLAZA MANOR CONVAL. HOME</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3401.4
TOWN <u>5427 N. CAREY ST. HOME</u>
STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)
<u>GLADYS T. Dadd.</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Oct 9 1957</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>SINGLE</u> | 8. DATE OF BIRTH
<u>AUG. 25, 1890</u> | 9. AGE last birthday
<u>67</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>UNEMPLOYED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA, NEWPORT NEWS</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>NONNIE C. DADD</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY P. WEBB</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no, or unk.)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS
<u>LINCOLN S. DADD 527 N. CAREY ST</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.0 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work <input type="checkbox"/> Not while el work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 56</u> , 19 <u>56</u> , to <u>Oct 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Joseph Tate</u> | | | | ADDRESS (Street, city, town, state) <u>102 B. A. Blvd. N.E. Glen Burnie, Md. 10-9-1</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION REMOVAL (SPECIFY)
<u>BURIAL</u> | | DATE THEREOF
<u>10/12/57</u> | | NAME OF CEMETERY OR CREMATORY
<u>ARBUTUS MEM PK.</u> | | LOCATION (City, town, or county) (State)
<u>ARBUTUS, A.A. Co. MD</u> | |
| 24. RECD BY REGISTRAR
<u>OCT 21 1957</u> | | REGISTRAR'S SIGNATURE
<u>L. G. Seabey</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Ernest D. Wilson</u> | | ADDRESS
<u>Brantley St.</u> | |

THE STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.
This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Department of Health of the State of Maryland.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

10150

DATE OF DEATH

AT WHAT PLACE AND IN WHAT COUNTY

NAME OF DECEASED

BUREAU V. S.

OCT 21 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10171

78

10203

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|------------------|---|-----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Anne Arundel</i> | | STATE <i>MARYLAND</i> | | STATE <i>District of Columbia</i> | | COUNTY <i>12th</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | ✓ | |
| TOWN <i>Crownsville PPD</i> | | <i>1 day</i> | | TOWN <i>Washington D.C. #27 16x0.2</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>449 Tudor Drive, Sunrise Beach</i> | | | | STREET ADDRESS (If rural give location) <i>4908 Alton St.</i> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <i>Thomas</i> (Middle) <i>-</i> (Last) <i>Damico</i> | | | | (Month) <i>Oct.</i> (Day) <i>12</i> (Year) <i>1957</i> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <i>Male</i> | <i>White</i> | <i>Married</i> | <i>March 26, 1898</i> | <i>59</i> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Bricklayer (ret.)</i> | | <i>Anthony Izzo, Inc.</i> | | <i>Italy</i> | | <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Luigi Damico</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Emelia (unknown)</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk. (If Yes, give war or dates of service)) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT & ADDRESS <i>Mrs. Emma Damico Same As #2</i> | |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>10 1/2 hrs</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that <i>the deceased from</i> <i>the PR</i> <i>to death</i> <i>that last saw the deceased</i> <i>alive on</i> <i>Oct. 10</i> <i>at</i> <i>5:30 P.M.</i> <i>from the causes and on the date stated above.</i>
SIGNATURE <i>Edward G. Thumt</i> ADDRESS (Street, city, town, state) <i>Chambers 17d</i> DATE SIGNED <i>10-13-57</i>
M.D. <i>Gambrell</i> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>Oct. 16/57</i> | | <i>Cedar Hill cem.</i> | | <i>Brooklyn PPD, Md.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <i>ACT 16 1957</i> | | <i>J. M. Joyce</i> | | <i>R. V. Singleton</i> | | <i>Ellen Brunie, Md.</i> | |

This Person transferred to Chambers funeral Home, Wash. D.C.

CERTIFICATE OF DEATH

10509

Reg. Dist. No.

1. Name of Deceased (Print or Type)

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Time of Death

8. Cause of Death

9. Manner of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of Other

16. Signature of Other

17. Signature of Other

18. Signature of Other

19. Signature of Other

20. Signature of Other

21. Signature of Other

22. Signature of Other

23. Signature of Other

24. Signature of Other

25. Signature of Other

26. Signature of Other

27. Signature of Other

28. Signature of Other

29. Signature of Other

30. Signature of Other

31. Signature of Other

32. Signature of Other

33. Signature of Other

34. Signature of Other

35. Signature of Other

36. Signature of Other

37. Signature of Other

38. Signature of Other

39. Signature of Other

40. Signature of Other

41. Signature of Other

42. Signature of Other

43. Signature of Other

44. Signature of Other

BUREAU V. 8

OCT 16 1957

RECEIVED

INVESTIGATION

LABORATORY OF MORBIDITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10156
CERTIFICATE OF DEATH

10172

Reg. Dist. No. 21

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b
35 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HUGO Middle DICKHOFF Last DICKHOFF | | 4. DATE OF DEATH
Month October Day 8 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 23, 1875 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months 82 Days 8 Hours 19 Min. 57 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ACCOUNTANT: Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 11. BIRTHPLACE (State or foreign country)
Berlin, Germany | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
EMIL DICKHOFF | | 14. MOTHER'S MAIDEN NAME
MATILDA STOMMEL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-03-0793A | |
| 17. INFORMANT
Mrs. Gertrude Tucker, Annapolis, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis
154x DUE TO leakage following abdomino-perineal resection of rectum and sigmoid colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO Adeno-carcinoma of rectum
(b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma left kidney and generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-25-1957 to 10-8-1957 , that I last saw the deceased alive on 10-8-1957 , and that death occurred at 12 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Jesse L. Wilkins M.D. | | ADDRESS (Street, city or town, state)
98 Cathedral St. Annapolis, Maryland | |
| DATE SIGNED
10-9-57 | | | |
| PHYSICIAN'S NAME (Type)
JESSE L. WILKINS, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
10-12-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State)
Prince George County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | ADDRESS
Annapolis, Maryland | |
| 24a. REC'D BY REGISTRAR
Am. J. Lench | | 24b. REGISTRAR'S SIGNATURE
Am. J. Lench | |
| DATE
OCT 14 1957 | | | |

| | | | |
|---|--|--|--|
| NAME OF DECEASED
Anne Arnold | | MARRIAGE
Married | |
| AGE
32 years | | SEX
Female | |
| PLACE OF BIRTH
Vineyard Town | | PLACE OF DEATH
Vineyard Town | |
| DATE OF BIRTH
Jan. 23, 1925 | | DATE OF DEATH
Jan. 23, 1957 | |
| CAUSE OF DEATH
Adeno-carcinoma of rectum | | MANNER OF DEATH
Natural | |
| SIGNATURE OF PHYSICIAN
J. J. Williams | | SIGNATURE OF REGISTRAR
J. J. Williams | |

BUREAU A. H.
RECEIVED
JAN 24 1957

| | | | |
|---|--|--|--|
| DATE OF DEATH
Jan. 23, 1957 | | PLACE OF DEATH
Vineyard Town | |
| CAUSE OF DEATH
Adeno-carcinoma of rectum | | MANNER OF DEATH
Natural | |
| SIGNATURE OF PHYSICIAN
J. J. Williams | | SIGNATURE OF REGISTRAR
J. J. Williams | |

CERTIFICATE OF DEATH

Reg. Dist. No.

10173

10204

| | | | |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Crownsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Whaleyville</u> 23x0.2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Crownsville State Hospital</u> | | d. STREET ADDRESS
<u>R.F.D.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>George</u> Middle <u>Edward</u> Last <u>Dickson</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>18</u> Year <u>1957</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> UNDIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Unknown</u> |
| 9. AGE (In years last birthday)
<u>67</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Unknown</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Unknown to us</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown to us</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>Apr 30, 1918 - July 18, 1919</u> | |
| 17. INFORMANT
<u>Hospital Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
450.0 DUE TO
(b) <u>Thrombophlebitis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>General Arteriosclerosis</u>
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>17 days</u>
<u>2 yrs 10 mos</u> |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. — p. m. — 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 2</u> , 1954, to <u>Oct 18</u> , 1957, that I last saw the deceased alive on <u>October 18</u> , 1957, and that death occurred at <u>7:45 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>[Signature]</u> | | ADDRESS (Street, city or town, state)
<u>Crownsville Md.</u> | |
| PHYSICIAN'S NAME (Type)
<u>Ludwig Benedict</u> | | DATE SIGNED
<u>10/18/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>10-22-57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Setonville Delaware</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles E. Neike Jr.</u> | | ADDRESS
<u>43 Northwest ANNAPOLIS MD.</u> | |
| 24a. REC'D BY REGISTRAR
<u>[Signature]</u> | | 24b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may retain the original copy of the certificate.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10205

Item 9 FilmG222 11-4-57 et

Reg. Dist. No.

10174

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>GLEN BURNIE</u> | | LENGTH OF STAY (in this place) <u>3 yrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104 ST. JAMES DRIVE</u> | | | | STREET ADDRESS (If rural give location) <u>104 ST. JAMES DRIVE</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>DOROTHY E. DONALDSON</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 23 1957</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>FEB. 9, 1921</u> | 9. AGE last birthday <u>36</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ROBERT GOETTE</u> | | | | 14. MOTHER'S, MAIDEN NAME <u>DAISY TITCHWELL</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT & ADDRESS <u>JAMES DONALDSON 104 ST. JAMES</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 416X IMMEDIATE CAUSE (A) <u>Massive Cerebral Embolism</u> | | | | | | <u>Instantly</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Left ventricular thrombosis</u> | | | | | | <u>2 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatic Heart Disease</u> | | | | | | <u>25 years</u> | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>8-15</u> , 19 <u>53</u> , to <u>10-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>57</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James R. Strabie</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. 1945 W. Balto. St. Balto 23, Md.</u> | | DATE SIGNED <u>10-24-57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>10-28-57</u> | | NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u> | | LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u> | |
| 24. REC'D BY REGISTRAR <u>UCT 25 1957</u> | | REGISTRAR'S SIGNATURE <u>L. J. Delaney</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>George K. Schwal</u> | | ADDRESS <u>2101 Frederick Ave</u> | |

RECEIVED
OCT 25 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10:57

CERTIFICATE OF DEATH

10175
Reg. Dist. No. 21

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X2 Arnold | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. NAVAL HOSPITAL | | d. STREET ADDRESS
Box 366, Riverside Drive | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Lonna Middle Charline Last DOWNEY | | 4. DATE OF DEATH
Month October Day 31 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6 March 1957 |
| 9. AGE (In years last birthday)
7 yrs. | | IF UNDER 1 YEAR
Months 7 Days 23 | |
| IF UNDER 24 HRS.
Hours 23 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| | | Maryland | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Jack Parker DOWNEY | | 14. MOTHER'S MAIDEN NAME
C. PATERICA LEE or THOMAS PARINTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
- - - | |
| 17. INFORMANT
U.S. Naval Hospital, Annapolis, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA with adrenal insufficiency
501X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tracheobronchitis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
20 hours | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. ft. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 31 October 1957 , to 31 October 1957 , that I last saw the deceased alive on 31 October 1957 , and that death occurred at 2:35 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Annapolis, Md. 1051 1957
ACTUAL SIGNATURE Francesco De Paolo M.D. U.S. Naval Hospital, Annapolis, Md. 1051 1957
PHYSICIAN'S NAME (Type) Francesco De PAOLO LT, Medical Corps, U.S. Naval Reserve | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 4, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Glen Burnie, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | 24a. REC'D BY REGISTRAR
NOV 5 1957 | |
| ADDRESS
Annapolis, Md. | | 24b. REGISTRAR'S SIGNATURE
Wm. J. French | |

CERTIFICATE OF DEATH

NAVY AND STATE DEPARTMENT - BUREAU OF HEALTH

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--------------------------------|--|
| NAME OF DECEASED
JACK PARTNER DOWNEY | | AGE
31 | | SEX
Male | | RACE
White | | DATE OF BIRTH
31 October 1927 | | PLACE OF BIRTH
Maryland | |
| FATHER'S NAME
JACK PARTNER DOWNEY | | MOTHER'S NAME
ANN PARTNER DOWNEY | | DATE OF DEATH
31 October 1957 | | PLACE OF DEATH
U.S. Naval Hospital, Annapolis, Maryland | | CAUSE OF DEATH
Septicemia with advanced intracranial extension of tracheobronchitis | | MANNER OF DEATH
Natural | |
| DATE OF INTERVIEW
31 October 1957 | | PLACE OF INTERVIEW
U.S. Naval Hospital, Annapolis, Maryland | | NAME OF PHYSICIAN
J. H. [illegible] | | NAME OF NURSE
[illegible] | | NAME OF CLERK
[illegible] | | NAME OF WITNESS
[illegible] | |

RECEIVED
NOV 5 1957
BUREAU V. 2

| | | | | | | | | | | | |
|--------------------------------------|--|--|--|--|--|------------------------------|--|------------------------------|--|--------------------------------|--|
| DATE OF INTERVIEW
31 October 1957 | | PLACE OF INTERVIEW
U.S. Naval Hospital, Annapolis, Maryland | | NAME OF PHYSICIAN
J. H. [illegible] | | NAME OF NURSE
[illegible] | | NAME OF CLERK
[illegible] | | NAME OF WITNESS
[illegible] | |
| DATE OF INTERVIEW
31 October 1957 | | PLACE OF INTERVIEW
U.S. Naval Hospital, Annapolis, Maryland | | NAME OF PHYSICIAN
J. H. [illegible] | | NAME OF NURSE
[illegible] | | NAME OF CLERK
[illegible] | | NAME OF WITNESS
[illegible] | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10206

CERTIFICATE OF DEATH

10177

Reg. Dist. No.

27

| | | | | | | | |
|--|--------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort George G. Meade</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort George G. Meade</u> X2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U. S. Army Hospital</u> | | | | d. STREET ADDRESS
<u>Hq 69th Sig Company</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>J.</u> Middle <u>C.</u> Last <u>DUNN</u> | | | | 4. DATE OF DEATH
Month <u>OCTOBER</u> Day <u>16</u> Year <u>19 57</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>NEG</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>20 November 1920</u> | | 9. AGE (In years last birthday)
<u>36</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Soldier</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Army</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Butler, Alabama</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Unknown (Deceased)</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown (Deceased)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>285-12-0479</u> | | 17. INFORMANT
<u>Personnel Records, Fort George G. Meade, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, malignant</u>
DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>15 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>0215 16 Oct 19 57</u> to <u>0315 16 Oct 57</u> , that I last saw the deceased alive on <u>16 Oct 1957</u> , and that death occurred at <u>0315 M</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>M.D. USAH, Fort G. G. Meade, Md.</u> DATE SIGNED <u>16 Oct 57</u>
ACTUAL SIGNATURE <u>Samuel D. Gaby</u>
PHYSICIAN'S NAME (Type) <u>SAMUEL D. GABY, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>REMOVAL</u> | | 22b. DATE THEREOF
<u>10/18/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>W Ross</u> | | 22d. LOCATION (City, town, or county) (State)
<u>1155 - Main St, Wargens, Ohio</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Earl B. Woberton Funeral Home, Inc</u>
<u>6306 - Belair Rd, Baltimore - 6, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>16 Oct 57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Wilbur H. Downs, Jr. Capt. MSG</u> | |

BUREAU V. S.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10178

10207 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A. A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD.</u> b. COUNTY <u>A. A. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudley</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudley</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Frances</u> Last <u>Duvall</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>9</u> Year <u>1957</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 19 1894</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR
Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>West River</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Joseph H. Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>Georgianne Hanmore</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Chesley Duvall</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial failure</u>
<u>260x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u>
DUE TO (c) <u>C. V. A.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Oct 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Lottman, Md.</u> DATE SIGNED <u>10-12-57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>Oct 13 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt Zion</u> | 22d. LOCATION (City, town, or county) (State)
<u>Lottman Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Bernard A. Hardy</u> | | 24a. REC'D BY REGISTRAR
<u>19/11/57</u> | |
| ADDRESS
<u>Belleville Md</u> | | 24b. REGISTRAR'S SIGNATURE
<u>J. J. ...</u> | |

CERTIFICATE OF DEATH

1957

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|--------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|-------------------------------|--|----------------------------|--|----------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. DATE OF DEATH | | 7. PLACE OF DEATH | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | | 10. SIGNATURE OF REGISTRAR | | 11. SIGNATURE OF DECEASED | | 12. SIGNATURE OF WITNESSES | | 13. SIGNATURE OF FUNERAL HOME | | 14. SIGNATURE OF PHYSICIAN | | 15. SIGNATURE OF CLERGYMAN | | 16. SIGNATURE OF OTHER | | 17. SIGNATURE OF OTHER | | 18. SIGNATURE OF OTHER | | 19. SIGNATURE OF OTHER | | 20. SIGNATURE OF OTHER | | 21. SIGNATURE OF OTHER | | 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | | 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | | 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | | 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | | 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | | 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | | 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | | 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | | 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | | 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | | 51. SIGNATURE OF OTHER | | 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | | 55. SIGNATURE OF OTHER | | 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | | 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | | 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | | 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | | 66. SIGNATURE OF OTHER | | 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | | 70. SIGNATURE OF OTHER | | 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | | 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | | 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | | 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | | 81. SIGNATURE OF OTHER | | 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | | 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | | 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | | 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | | 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | | 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | | 100. SIGNATURE OF OTHER | |
|---------------------|--|--------|--|--------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|--------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|-------------------------------|--|----------------------------|--|----------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|

BUREAU V. 3

OCT 21 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY ANN ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE, MD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STENBURNIE, R.F.D. #2, Box 376 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, MD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Plaza Manor Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
VICTORIA DYSON | | | | 4. DATE OF DEATH
Month Day Year
OCT. 23rd 19 57 | | | |
| 5. SEX
F | 6. COLOR OR RACE
C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/31/1885 | | 9. AGE (In years last birthday)
72 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | | 11. BIRTHPLACE (State or foreign country)
HOWARD COUNTY, MD | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
EMANUEL WATKINS | | | | 14. MOTHER'S MAIDEN NAME
MARY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NO | | 17. INFORMANT
Address
MARY V. PARKER-1913 BENTALOU ST | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 Yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 20 19 57 , to October 23 19 57 , that I last saw the deceased alive on October 20 19 57 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 400 N. CARROLLTON AV DATE SIGNED October 24 1957 | | | | | | | |
| ACTUAL SIGNATURE
James M. Fair | | | | PHYSICIAN'S NAME (Type)
DR. JAMES M. FAIR | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 10/25/57 | | Not Auburn | | Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles H. Cripe | | | | ADDRESS
512 Carrollton | | 24a. REC'D BY REGISTRAR
DATE 10/28/57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
L. J. Dealy | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYFIELD STATE DEPARTMENT OF HEALTH—BATHING, 18

BUREAU V. S.

201 02 1957

RECEIVED

10209

CERTIFICATE OF DEATH

Reg. Dist. No.

24

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY A. A. Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lake Shore | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lake Shore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mountain Rd. | | | | d. STREET ADDRESS
Mountain Rd. - Box 383 | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle BURT Last EBAUGH | | | | 4. DATE OF DEATH
Month Oct. Day 13, Year 1957 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 11, 1884 | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist (rtd) | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Mfg. | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-07-5207 | | 17. INFORMANT
Mrs. Martha E. Ebaugh - Mountain Rd., Lake Shore | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-hypertensive vascular diseases
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 1954 , 19____, to October 13th , 19 57 , that I last saw the deceased alive on 10/13/57 , 19____, and that death occurred at 4 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Gustave H. Faubert, M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED 5-Finish Rd. P. E. Glen Burnie Md | | | |
| PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/16/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
WM. J. TICKNER & SONS - Balto. 17, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 17 1957 | | 24b. REGISTRAR'S SIGNATURE
L. J. Seallap | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17-27-10

(continued)

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10181

10210

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Mississippi b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holka 61X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First Arthur Middle Elliot Last | | 4. DATE OF DEATH
Month 10 Day 21 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1885 |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Mississippi | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John Elliott | | 14. MOTHER'S MAIDEN NAME
Sallie Steen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic Pneumonia
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b) Congestive Heart Failure
(c) Generalized Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/1 , 19 31 , to 10/21 , 19 57 , that I last saw the deceased alive on 10/21 , 19 57 , and that death occurred at 12:50 P. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. Benedict, M. D. | | ADDRESS (Street, city or town, state) Crownsville, Md. | |
| PHYSICIAN'S NAME (Type) L. Benedict, M. D. | | DATE SIGNED 10/21/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 10.22.57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
U. of Md. Med. School | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Reese | | ADDRESS
1087 Wash St | |
| 24a. REC'D BY REGISTRAR
10/23/57 | | 24b. REGISTRAR'S SIGNATURE
J. M. Joyce | |

BUREAU V. S.

OCT 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

- MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
10158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10182

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Anne Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY <i>CC</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | | c. LENGTH OF STAY IN 1b
<i>10</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>3 Monticello Ave</i> | | d. STREET ADDRESS
<i>3 Monticello Ave</i> | |
| 3. NAME OF DECEASED
(Type or print)
First <i>HARRY</i> Middle <i>WIGGINS</i> Last <i>FORD</i> | | 4. DATE OF DEATH
Month <i>Oct</i> Day <i>30</i> Year <i>1957</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Aug 13th 1904</i> |
| 9. AGE (In years last birthday) <i>53</i> yrs. | | IF UNDER 1 YEAR
Months <i>0</i> Days <i>0</i> | IF UNDER 24 HRS.
Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Printer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>News Paper</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Lancaster Pa</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>David L. Ford</i> | | 14. MOTHER'S MAIDEN NAME
<i>May L. Wiggins</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>John T. Ford</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Shriven Alcoholism</i>
DUE TO <i>322.1</i>
Conditions, if any, which gave rise to immediate cause (b) _____
(c), stating the underlying cause lost. DUE TO (c) _____ | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. TIME OF INJURY Month, Day, Year
Hour <i>19</i> o. m. p. m. | |
| 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) | | 20f. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<i>E. Linhardt</i> | | DATE SIGNED
<i>11-2-57</i> | |
| EXAMINER'S NAME (Type)
<i>E. Linhardt</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Removal</i> | | 22b. DATE THEREOF
<i>11-2-57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>John M. Day Co. Annapolis Md</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Linghestown Pa</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>John M. Day</i> | | 24a. REC'D BY REGISTRAR
<i>11/4/57</i> | |
| 24b. REGISTRAR'S SIGNATURE
<i>11-2-57</i> | | | |

NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 6 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10211
 Items 8,9: G221 10-22-57L

CERTIFICATE OF DEATH

10183
 Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Edgewater</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mayo, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Carl</u> Middle <u>Andreas</u> Last <u>Forslund</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>7</u> Year <u>1957</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1912</u>
<u>6-19-1912</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>TRUCK</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Sweden</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Andreas Forslund</u> | | 14. MOTHER'S MAIDEN NAME
<u>Helena Granbsted</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs. C. A. Forslund</u> | | Address <u>#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct. 7</u> , 19 <u>57</u> , at <u>12:10 AM</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>57</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Sylvia M. Lim</u> | | ADDRESS (Street, city or town, state)
<u>RFD #1 Box 277-M Edgewater, Maryland</u> | |
| PHYSICIAN'S NAME (Type)
<u>Sylvia M. Lim</u> | | DATE SIGNED
<u>Oct. 7, 1957</u> | |
| 22a. BURIAL, CREMATION, or other disposition | 22b. DATE THEREOF
<u>10-9-57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Greencrest</u> | 22d. LOCATION (City, town, or county) (State)
<u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Saylor Sons</u> | | 24a. REC'D BY REGISTRAR
<u>10/8/57</u> | |
| ADDRESS
<u>Annapolis Md</u> | | 24b. REGISTRAR'S SIGNATURE
<u>V. Ormick</u> | |

BUREAU

1957 10 OCT

RECEIVED

10212

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glenburnie</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glenburnie</u> <u>XO</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Plaza Manor</u> | | d. STREET ADDRESS
<u>Lee Road</u> <u>1</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>Alfred</u> Last <u>Fredericks</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>26</u> Year <u>1957</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 7, 1886</u> |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Post Office</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Fredericks</u> | | 14. MOTHER'S MAIDEN NAME
<u>Henrietta Hall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>Mrs. Violette E. James</u> Address
<u>1340 N. Carey Street</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>October 1, 1957</u> , to <u>October 25, 1957</u> , that I last saw the deceased alive on <u>October 23, 1957</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>James M. Pair</u> | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>400 N. Carrollton Avenue</u> <u>10.29.57</u> | |
| PHYSICIAN'S NAME (Type)
<u>James M. Pair M.D.</u> | | <u>Baltimore 23, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct. 29, 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Auburn</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Holland Funeral Home</u> | | ADDRESS
<u>1631 Druid Hill Ave.</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>10/30/57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>L. J. K. Albany</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1967 OCT 4

RECEIVED

10213

CERTIFICATE OF DEATH

Reg. Dist. No.

38

| | | | | | | | |
|--|--|---|--|---|--|--------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | | | c. LENGTH OF STAY IN 1b
6 ys. 2 mos. 19d. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Crownsville State Hospital, Md. | | | | d. STREET ADDRESS
West Road | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle Jackson Last Furness | | | | 4. DATE OF DEATH
Month 10 Day 2 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
9/23/1896 | |
| 9. AGE (In years last birthday)
61 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
George W. Furness | | | | 14. MOTHER'S MAIDEN NAME
Nellie Bly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
W. W. 1 219-07-6035 | | | |
| 17. INFORMANT
Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
572.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b) Suppurative Peritonitis
(c) Chronic Ulcerative Colitis with perforation | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome associated with Arteriosclerosis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. ----- 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 7/13 , 19 51 , to 10/2 , 19 57 , that I last saw the deceased alive on 10/2 , 19 57 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<i>L. Benedict</i> | | | | ADDRESS (Street, city or town, state)
Crownsville, Md. | | | |
| PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | | | DATE SIGNED
10/2/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 22b. DATE THEREOF
10/5/57 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Green Acre Inc. | | | | 22d. LOCATION (City, town, or county) (State)
Salisbury Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Clinton F. Stewart</i> | | | | ADDRESS
Salisbury Md. | | | |
| 24a. REC'D BY REGISTRAR
OCT 9 1957 | | | | 24b. REGISTRAR'S SIGNATURE
<i>L. M. Joyce</i> | | | |

RECEIVED
OCT 9 1957
BUREAU

10159

CERTIFICATE OF DEATH

10186

Reg. Dist. No.

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>10 Annapolis, MD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>A.A. General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>HAMILTON ADAMS GALE</u> | | 4. DATE OF DEATH
Month Day Year
<u>10 2 1957</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-12-1908</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ENGINEER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Air Conditioning</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>HAMILTON A. GALE</u> | | 14. MOTHER'S MAIDEN NAME
<u>Alice Loomis</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) | | 16. SOCIAL SECURITY NO.
<u>Lucy D. GALE #2</u> | |
| 17. INFORMANT
<u>Lucy D. GALE</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Leukemia</u>
260x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Kennel-Steel Wilson Disease</u>
DUE TO
(c) <u>Diabetes M.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks</u>
<u>3 yrs.</u>
<u>2 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4 - - - - -</u> , 19 <u>57</u> , to <u>10-2-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-2-57</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Frank M. Shipley</u> | | ADDRESS (Street, city or town, state)
<u>63 College Ave Annapolis</u> | |
| PHYSICIAN'S NAME (Type)
<u>Frank M. Shipley</u> | | DATE SIGNED
<u>10-4-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>10-5-1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>ST. ANNE'S</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Annapolis MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Taylor & Sons</u> | | ADDRESS
<u>Annapolis, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>10/4/57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

OCT 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10214

CERTIFICATE OF DEATH

Reg. Dist. No.

1018738

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
4ys.2mos.22d. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Crownsville State Hospital, Md. | | d. STREET ADDRESS
1820 E. Fayette St. | |
| 3. NAME OF DECEASED (Type or print)
First Walter Middle Anderson Lee Last Newson German | | 4. DATE OF DEATH
Month 10 Day 9 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/6/38 |
| 9. AGE (In years last birthday)
18 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Walter Rock | | 14. MOTHER'S MAIDEN NAME
Pauline Anderson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
101-15-57 | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia confluent
491x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Convulsive Disorders with
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Behavior Reactions | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. ft. p. m. ----- 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7/17/53 , 19____, to October 9 , 19 57 , that I last saw the deceased alive on October 9 , 19 57 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE [Signature] | | ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/12/57 | |
| PHYSICIAN'S NAME (Type) L. Benedict, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10-15-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
MOUNT CALVARY CEM | | 22d. LOCATION (City, town, or county) (State)
ARUNDEL Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Isaiah L. Brown & Son | | 24a. REC'D BY REGISTRAR
10/18/57 | |
| ADDRESS
108 W. MONTGOMERY ST. BALTO MD. | | 24b. REGISTRAR'S SIGNATURE
[Signature] | |

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10161 **CERTIFICATE OF DEATH**

10189

Reg. Dist. No.

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
o. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE MD. b. COUNTY A.A. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. GENERAL Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HAZEL VOIT GILLMER | | 4. DATE OF DEATH 10 17 1957 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-5-1885 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME | | 10b. KIND OF BUSINESS OR INDUSTRY HEHEWITE | |
| 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME CHARLES VOIT | | 14. MOTHER'S MAIDEN NAME HELEN WONDERS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT THOMAS C. GILLMER Address #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease
DUE TO (c) Arteriosclerosis, Generalized | | INTERVAL BETWEEN ONSET AND DEATH
1 wk.
1 hr.
1 hr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour ' o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1, 1954 to Oct 17, 1957 , that I last saw the deceased alive on Oct 17, 1957 , and that death occurred at M , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James R. Martin M.D. | | ADDRESS (Street, city or town, state) 6 SHAW ST. ANNAPOLIS, MD. | |
| PHYSICIAN'S NAME (Type) JAMES R. MARTIN | | DATE SIGNED 10/18/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-21-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY OAK WOOD | | 22d. LOCATION (City, town, or county) (State) WARREN OHIO | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR 10/18/57 24b. REGISTRAR'S SIGNATURE J. J. ... | |

CERTIFICATE OF DEATH

10-1-67

NAME: [illegible]
 SEX: [illegible]
 AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE: [illegible]
 DATE: [illegible]

10-1-67

NAME: [illegible]
 SEX: [illegible]
 AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE: [illegible]
 DATE: [illegible]

BUREAU V. S.

OCT 21 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10190

10215

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Pr. George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
1yr, 9mo, 22ds | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State | | d. STREET ADDRESS
Route 1 | |
| 3. NAME OF DECEASED (Type or print)
First Luell Middle Gross Last Gross | | 4. DATE OF DEATH
Month 10 Day 28 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/2/1886 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR
Months 7 Days 1 Hours 1 Min. 1 | IF UNDER 24 HRS.
Hours 1 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
George Gross | | 14. MOTHER'S MAIDEN NAME
Mattie Thomason | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Hospital Records | | Address
----- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular Disease
DUE TO (c) ----- | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. ----- p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/6 , 19 56 to 10/28 , 19 57 , that I last saw the deceased alive on 10/28 , 19 57 , and that death occurred at 8:30A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/29/57
ACTUAL SIGNATURE Conwell Newton M.D.
PHYSICIAN'S NAME (Type) Conwell Newton, M. D. Crownsville State Hospital, M.d | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
11-1-57 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Luke Methodist | |
| 22d. LOCATION (City, town, or county) (State)
Upper Marlboro Md | | 22e. REC'D BY REGISTRAR
11-1-57 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Henry S. Washington + Sons | | 24b. REGISTRAR'S SIGNATURE
H. M. Joyce | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED
[REDACTED]</p> | | <p>2. SEX
[REDACTED]</p> | |
| <p>3. AGE
[REDACTED]</p> | | <p>4. DATE OF BIRTH
[REDACTED]</p> | |
| <p>5. PLACE OF BIRTH
[REDACTED]</p> | | <p>6. OCCUPATION
[REDACTED]</p> | |
| <p>7. MARITAL STATUS
[REDACTED]</p> | | <p>8. CAUSE OF DEATH
[REDACTED]</p> | |
| <p>9. MEDICAL HISTORY
[REDACTED]</p> | | <p>10. SIGNATURE OF PHYSICIAN
[REDACTED]</p> | |
| <p>11. SIGNATURE OF REGISTRAR
[REDACTED]</p> | | <p>12. DATE OF DEATH
[REDACTED]</p> | |
| <p>13. PLACE OF DEATH
[REDACTED]</p> | | <p>14. SIGNATURE OF WITNESS
[REDACTED]</p> | |
| <p>15. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>16. SIGNATURE OF NEXT OF KIN
[REDACTED]</p> | |
| <p>17. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>18. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>19. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>20. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>21. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>22. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>23. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>24. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>25. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>26. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>27. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>28. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>29. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>30. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>31. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>32. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>33. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>34. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>35. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>36. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>37. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>38. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>39. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>40. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>41. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>42. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>43. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>44. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>45. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>46. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>47. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>48. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>49. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>50. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>51. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>52. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>53. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>54. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>55. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>56. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>57. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>58. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>59. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>60. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>61. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>62. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>63. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>64. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>65. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>66. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>67. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>68. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>69. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>70. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>71. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>72. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>73. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>74. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>75. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>76. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>77. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>78. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>79. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>80. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>81. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>82. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>83. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>84. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>85. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>86. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>87. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>88. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>89. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>90. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>91. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>92. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>93. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>94. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>95. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>96. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>97. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>98. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>99. SIGNATURE OF DECEASED
[REDACTED]</p> | | <p>100. SIGNATURE OF DECEASED
[REDACTED]</p> | |

RECEIVED
NOV 4 1937
BUREAU V. S.

10216

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11437

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) Lothian LENGTH OF STAY (in this place) Life?HOSPITAL OR INSTITUTION OR STREET ADDRESS None

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne ArundelCITY (If outside corporate limits write RURAL and give nearest town) Lothian

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:
(Type or Print)(First) (Middle) (Last)
Richard Gross4. DATE OF DEATH (Month) (Day) (Year)
10 28 1957

5. SEX:

Male Negro

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 4/12/939. AGE Last birthday: 64 yrs.IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farming10b. KIND OF BUSINESS OR INDUSTRY: Tobacco11. BIRTHPLACE (State or foreign country): Tracy's Landing Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

WILLIAM F. GROSS

14. MOTHER'S MAIDEN NAME:

Catherine Neale15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes WWI

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Eug Gross, Lothian Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause 420.1

(a) DUE TO

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Cardiac decompensation

(c)

Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

Immediate2+ years2+ years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Overexertion

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐ , Inspection ☒ , Inquiry ☐ , and find that death resulted from: Natural causes ☒ , Accident ☐ , Suicide ☐ , Homicide ☐ , Undetermined cause ☐ .

SIGNATURE

F. D. H. Endruch

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM.

10-30-57

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10191

10217

CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade | | | | c. LENGTH OF STAY IN IB 1 da 8hr 55min | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn x2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital | | | | d. STREET ADDRESS Box 75A | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DEBBRA Middle LYNN Last GUNTER | | | | 4. DATE OF DEATH Month October Day 3 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1 October 1957 | |
| 9. AGE (In years last birthday) yrs. 33 | | IF UNDER 1 YEAR Months 1 Days 8 Hours 55 | | IF UNDER 24 HRS. 33 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Clarence Gunter, Jr. | | | | 14. MOTHER'S MAIDEN NAME Ursula Ida Lobe | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Father, Box 75A, Severn, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity Prematurity
776x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
INTERVAL BETWEEN ONSET AND DEATH 1 da 8hr 55min | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1 Oct , 19 57 , to 3 Oct , 19 57 , that I last saw the deceased alive on 3 Oct 3 Oct 19 57 57 and that death occurred at 0840M , from the causes and on the date stated above.
0840 ADDRESS (Street, city or town, state) USA, Ft. G. G. Meade, Maryland DATE SIGNED 3 Oct 57
ACTUAL SIGNATURE Frank L. Gruskay
PHYSICIAN'S NAME (Type) FRANK L. GRUSKAY, MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct-4-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Frederick Road Ind | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl B. Watson Funeral Home Inc
6306 Belair Rd Baltimore Md | | | | 24. REC'D BY REGISTRAR DATE 3 Oct 57 | | 24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSG | |

BUREAU V. S.

OCT 7 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10192

Reg. Dist. No.

21

10218

| | | | | | | | |
|---|---|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RURAL ANNAPOLIS</u> | | c. LENGTH OF STAY IN 1b
<u>16 YRS.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X2 RURAL ANNAPOLIS</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>MULBERRY HILL Rd.</u> | | | | d. STREET ADDRESS
<u>MULBERRY HILL</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>LYDIA</u> Middle <u>R.</u> Last <u>GANTHER</u> | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>3</u> Year <u>1957</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 19, 1871</u> | 9. AGE (In years last birthday)
<u>86</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>HENRY GREBE</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>KATHERINE MILLER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>HERMAN GANTHER</u> Address <u>R.F.D. 4 ANNAPOLIS</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO (b) <u>151X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<u>E. L. HART</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>E. L. HART</u> | | DATE SIGNED
<u>10/3/57</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>10-7-57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>London Park</u> | | 22d. LOCATION (City, town, or county)
<u>BALTIMORE Md.</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>George E. Schwal</u> | | ADDRESS
<u>2101 Frederick Ave. Baltimore, Md.</u> | | 24a. REC'D BY REGISTRAR
<u> </u> | | 24b. REGISTRAR'S SIGNATURE
<u> </u> | |
| | | DATE
<u>OCT 7 1957</u> | | | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 7 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10162

CERTIFICATE OF DEATH

Reg. Dist. No. 10193

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Anne Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>10 Annapolis</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>535 Horn Point Drive</i> | | d. STREET ADDRESS
<i>1535 Horn Point Drive</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Le Roy</i> Middle <i>Habersank</i> Last <i>Habersank</i> | | 4. DATE OF DEATH
Month <i>October</i> Day <i>17</i> Year <i>1957</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OF RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>4-23-1895</i> |
| 9. AGE (In years last birthday) <i>62</i> yrs. | | IF UNDER 1 YEAR
Months <i>62</i> Days <i>62</i> Hours <i>62</i> Min. <i>62</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Clothing Cutter</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Tailoring</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Charles Habersank</i> | | 14. MOTHER'S MARDEN NAME
<i>Kate High</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i> <i>WW I</i> | | 16. SOCIAL SECURITY NO.
<i>WW I</i> | |
| 17. INFORMANT
<i>Eva Habersank</i> | | Address <i># 2</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma Lung</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>169X</i>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1 year</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>JAN 156</i> , 19 <i>57</i> , to <i>Oct 17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 17</i> , 19 <i>57</i> , and that death occurred at <i>10:17</i> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | M.D. <i>Amegels Haupt</i> | |
| PHYSICIAN'S NAME (Type)
<i>E. LINHARDT</i> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>10-19-57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>John H. Taylor & Son</i> | | ADDRESS
<i>Annapolis, Md.</i> | |
| 24a. REC'D BY REGISTRAR
<i>10/18/57</i> | | 24b. REGISTRAR'S SIGNATURE
<i>J. Trunch</i> | |

BUREAU V. S.

OCT 21 1957

RECEIVED

10219 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

101948
Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>A. A.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brambills</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Brambills, MD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print) <u>Thomas</u> First <u>Fall</u> Middle <u>is</u> Last | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>1</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Color</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jun. 18/ 1877</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR: Months <u>8</u> Days <u>18</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor / Hotel Bus. made</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Amaphis Jct</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Hall</u> | | 14. MOTHER'S MAIDEN NAME <u>Annal (Unknown)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>216-185087</u> | |
| 17. INFORMANT <u>Mr. Francis Hall</u> Address <u>552 Bold St Baltimore</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u></u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>9/27/57</u> 19 <u>57</u> to <u>9/30/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/30/57</u> , 19 <u>57</u> , and that death occurred at <u>12 A</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John K. Alexander</u> M.D. | | DATE SIGNED <u>10/4/57</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN C. ALEXANDER</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 17 1957</u> | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u> | 22d. LOCATION (City, town, or county) (State) <u>Brambills MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u> ADDRESS <u>Annapolis</u> | | 24a. REC'D BY REGISTRAR DATE <u>Oct 8 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>H. M. Joyce</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10195

Reg. Dist. No. 25

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|--|------------------------------|---|------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Same b. COUNTY Same | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 25 | | c. LENGTH OF STAY IN 1b
Over 3 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Same X 2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
5743 Bellegrove Rd. | | | | d. STREET ADDRESS
Same | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Sarah Mathilda Hines | | | | 4. DATE OF DEATH Oct. 13th, 1957 19 | | | |
| 5. SEX
F | 6. COLOR OR RACE
C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/27/87 | | 9. AGE (In years last birthday)
70 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
A.A. County, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Benjamin Snowden | | | | 14. MOTHER'S MAIDEN NAME
Sarah Queen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs. Mary A. Gibson (daughter) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause lost. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Gustave H. Faubert</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Gustave H. Faubert, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/13/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
October 16, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Mount Calvary Cemetery | | 22d. LOCATION (City, town, or county) (State)
Brookland, A.A. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Choy C. Wilson</i> | | | | ADDRESS
<i>1000 Brantley Ave.</i> | | 24a. RECD BY REGISTRAR
OCT 21 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>Joe Hubson</i> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10163

CERTIFICATE OF DEATH

10197

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Severna Park</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Funeral</u> | | d. STREET ADDRESS <u>1 Rt 1 Box 104A</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Gail</u> Middle <u>(n)</u> Last <u>Hume</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-19-1957</u> |
| 9. AGE (In years last birthday) yrs. <u>7</u> | | IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United Kingdom</u> | |
| 13. FATHER'S NAME <u>Peter D. Hume</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Marshall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Peter D. Hume</u> Address <u># 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PREMATURE</u>
776x DUE TO <u></u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>19 Oct</u> , 19 <u>57</u> , to <u>20 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 Oct</u> , 19 <u>57</u> , and that death occurred at <u>9⁰⁰</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Carl Helt, M.D.</u> | | ADDRESS (Street, city or town, state) <u>1301 5th St</u> DATE SIGNED <u>10/25/57</u> | |
| PHYSICIAN'S NAME (Type) <u>STUART H. WITKOWSKI M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-23-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Near Annapolis Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR <u>10/25/57</u> | 24b. REGISTRAR'S SIGNATURE <u>J. D. [Signature]</u> |

2063262 XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. S.

OCT 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10198

10221

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Fred Middle Lee Last Hunter | | 4. DATE OF DEATH
Month 10 Day 26 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
3/3/21 |
| 9. AGE (In years last birthday)
36 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Worker in Shipyard | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John Hunter | | 14. MOTHER'S MAIDEN NAME
Maggie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
490x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pulmonary gangrene
(c) Lobar Pneumonia
INTERVAL BETWEEN ONSET AND DEATH
48 hours
Unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Alcoholism with Delirium Tremens | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. ft. p. m. ----- 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State)
----- | |
| 21. I certify that I attended the deceased from 10/24 , 19 57 , to 10/26 , 19 57 , that I last saw the deceased alive on 10/26 , 19 57 , and that death occurred at 8:10 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>Ludwig Benedict</i> | | ADDRESS (Street, city or town, state)
Crownsville, Md. | |
| PHYSICIAN'S NAME (Type)
Ludwig Benedict, M. D. | | DATE SIGNED
10/28/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10-31-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
BALTO-NATIONAL BALTIMORE | | 22d. LOCATION (City, town, or county) (State)
Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
WILLIAM A. JACKSON INC. | | 24a. REC'D BY REGISTRAR
DATE 1 1957 | |
| ADDRESS
NO | | 24b. REGISTRAR'S SIGNATURE
<i>Katharine Joyce</i> | |

RECEIVED

NOV 1 1957

BUREAU V. 4

For reference

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10222

CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE OF DEATH *Oct. 25/1957*1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

8/2/57

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *10/25* *1957*, that (I) (we) last saw the deceased alive on *10/25* *1957*, and that death occurred at *11:45* *Pm.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☐MED. DIRECTOR ☐STAFF PHYS. ☐

Medical Arts Building

10/28/57

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10-28-57

A. H. Hedrick & Son 10016 Fort

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg
HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10200

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Earleigh Heights
c. LENGTH OF STAY IN 1b
3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
In the front seat of a truck. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓
3v01.4
d. STREET ADDRESS
935 Somerset St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
John Jacobs
First Middle Last
5. SEX
M
6. COLOR OR RACE
C
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
1/28/06
9. AGE (in years last birthday)
51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer Baltimore Transit Co.
10b. KIND OF BUSINESS OR INDUSTRY
Marion, S.C.
11. BIRTHPLACE (State or foreign country)
U.S.A.
12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 4. DATE OF DEATH
October 12th, 1957
Month Day Year
13. FATHER'S NAME
Willie Jacobs
14. MOTHER'S MAIDEN NAME
?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No
16. SOCIAL SECURITY NO.
No
17. INFORMANT
Mrs. Eva Jacobs (wife)
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
Sudden | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19
20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Gustave H. Faubert
EXAMINER'S NAME (Type)
Gustave H. Faubert, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/12/57
DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
22b. DATE THEREOF
10-16-57
22c. NAME OF CEMETERY OR CREMATORY
St. Calvary Cem.
22d. LOCATION (City, town, or county) (State)
A. A. Co Md | | 23. FUNERAL DIRECTOR'S SIGNATURE
Rayner Sanders
ADDRESS
217 E. Preston
24a. REC'D BY REGISTRAR
10/15/57
24b. REGISTRAR'S SIGNATURE
L. J. Deall | |

RECEIVED

OCT 16 1957

BUREAU V. S.

10224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG221 10-11-57 et

Reg. Dist. No.

28

| | | | |
|---|----------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>A.M.Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville - State - Hosp.</i> | | d. STREET ADDRESS <i>1608 W. Lafayette Ave.</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>James</i> Middle <i>JANEY</i> Last | | 4. DATE OF DEATH
Month <i>10</i> Day <i>5</i> Year <i>1957</i> | |
| 5. SEX <i>M.</i> | 6. COLOR OR RACE <i>C.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Oct. 15, 1893</i> |
| 9. AGE (In years last birthday) <i>63</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Slaughter House</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>John H. Janey</i> | | 14. MOTHER'S MAIDEN NAME <i>Irene Bowie</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INDEMNITY Address <i>Mary Janey 1608 W. Lafayette Ave.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Suicide -</i>
DUE TO <i>Strangulation. (S)</i>
Conditions, if any, which gave rise to immediate cause (b) <i>Suicide</i>
(c) <i>Suicide</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shee Shee stray across neck + hung self</i> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <i>10/5/57</i> 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hospital</i> | | 20f. (City or town) (County) (State) <i>BALTO MD MD</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>E. Linhardt</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Oct. 8, 1957</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Abraham Memorial</i> | | 22d. LOCATION (City, town, or county) (State) <i>BALTO MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Kate R. Williams</i> | | ADDRESS <i>Schroeder St</i> | |
| 24a. REC'D BY REGISTRAR <i>OCT 8 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>K. M. Joyce</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COCAINE

DEATH

DEATH

BUREAU V. 8

OCT 9 1957

RECEIVED

10164

CERTIFICATE OF DEATH

Reg. Dist. No.

10202

| | | | | | | | |
|--|----------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Virginia b. COUNTY Norfolk | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Norfolk (Merrimack Park) 83x-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | | | e. STREET ADDRESS
8819 Monitor Way | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First BABY Middle BOY Last JOHNSON | | | | 4. DATE OF DEATH
Month October Day 16 Year 1957 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 15, 1957 | | 9. AGE (In years last birthday)
yrs. 2 | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 | IF UNDER 24 HRS.
Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Annapolis, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Johnson | | | | 14. MOTHER'S MAIDEN NAME
Irene Kinley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mrs Irene Johnson- Mother- same as # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 773.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chewaturny
(c) Pericard Disease (?) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-15-57 to 10-16-57 , that I last saw the deceased alive on 10-16-57 , 19 57 , and that death occurred at 3:20 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 62 Cothran St 10-14-57 DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE A. T. Allen | | M.D. 62 Cothran St 10-14-57 | | | | | |
| PHYSICIAN'S NAME (Type) A T ALLEN | | Annapolis, Md | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
October 24, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State)
Norfolk, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
HOPPING FUNERAL HOME | | | | ADDRESS
ANNAPOLIS, MARYLAND | | 24a. REC'D BY REGISTRAR
DATE 28 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Am J French | | | |

2063181XV8

1957 28 OCT

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10225

CERTIFICATE OF DEATH

10203
Reg. Dist. No.

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
3ys, 6mo. 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | e. STREET ADDRESS
Graddock Nursing Home | |
| 3. NAME OF DECEASED (Type or print)
First Daisy Middle King Last Johnson | | 4. DATE OF DEATH
Month 10 Day 29 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Unknown |
| 9. AGE (In years last birthday)
68 1/2 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | |
| 11. BIRTHPLACE (State or foreign country)
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
George King | | 14. MOTHER'S MAIDEN NAME
Elizabeth | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.
(b) Hypostatic Condition
DUE TO
(c) Carcinoma of cervix with Senility | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome associated with Arteriosclerosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. ----- 19
p. m. ----- | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State)
----- | |
| 21. I certify that I attended the deceased from April 28 , 19 54 to October 29 , 19 57 , that I last saw the deceased alive on October 29 , 19 57 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/30/57 | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | M.D. ----- | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/1/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Crownsville State Hospital | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Reese | | 24a. REC'D BY REGISTRAR
11/5/57 | |
| ADDRESS
108 Wash. St. Annapolis, Md. | | 24b. REGISTRAR'S SIGNATURE
L. M. Joyce | |

BUREAU

NOV 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or interment.

VS. A15ME(5)

10165

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10204

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>AA</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <i>MD</i> b. COUNTY <i>AA</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>A A General</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>10 Annapolis</i> | |
| 3. NAME OF DECEASED (Type or print)
<i>Albert P. Johnston</i> | | d. STREET ADDRESS
<i>1140 Eastport Terrace</i> | |
| 4. DATE OF DEATH
Month <i>10</i> - Day <i>22</i> Year <i>1957</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>11-26-1888</i> |
| 9. AGE (in years last birthday)
<i>68</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Pump Station Opp.</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>John Johnston</i> | | 14. MOTHER'S MAIDEN NAME
<i>Belle Wilson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Margaret L Johnston</i> Address <i>(2)</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Disease</i>
DUE TO <i>434.3</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<i>E. L. Johnston</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<i>Annapolis Md</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
<i>10/24/57</i> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>10-26-57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Hillcrest Cem</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Annapolis Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>John W. Taylor Sons</i> | | 24a. REC'D BY REGISTRAR
<i>10/24/57</i> | |
| ADDRESS
<i>Annapolis Md</i> | | 24b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
10102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

OCT 23 1957

RECEIVED

10226

CERTIFICATE OF DEATH

1020521

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>a. a. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
o. STATE <u>Maryland</u> o. COUNTY <u>a. a. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md. x0</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewater Md.</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Osiah</u> First <u>Jones</u> Middle <u>Jones</u> Last | | 4. DATE OF DEATH <u>10-9-</u> 19 <u>57</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-1-1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>C. Knighton</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>?</u> | | 14. MOTHER'S MAIDEN NAME <u>Amelia Hicks</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Herbert Jones Edgewater Md.</u> | |
| 17. INFORMANT <u>Herbert Jones Edgewater Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Hypertension</u>
<u>443x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease Grade III</u>
DUE TO (c) <u>3 months</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 8, 1957</u> , to <u>Sept 9, 1957</u> , that I last saw the deceased alive on <u>Sept 9, 1957</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D. | | ADDRESS (Street, city or town, state) <u>110-CLAY STREET ANNAPOLIS, MD.</u> DATE SIGNED <u>10/11/57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>10-13-57</u> | <u>Christ the King</u> | <u>Davidsonville Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beebe</u> ADDRESS <u>#108 West St. Annapolis</u> | | 24a. REC'D BY REGISTRAR <u>10/14/57</u> DATE | 24b. REGISTRAR'S SIGNATURE <u>Thm. J. Funch</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF JUDGE | | 17. SIGNATURE OF CLERK | | 18. SIGNATURE OF SHERIFF | |
| 19. SIGNATURE OF DEPUTY SHERIFF | | 20. SIGNATURE OF CONSTABLE | | 21. SIGNATURE OF JURY | |
| 22. SIGNATURE OF JURY | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF JURY | |
| 25. SIGNATURE OF JURY | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF JURY | |
| 28. SIGNATURE OF JURY | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF JURY | |
| 31. SIGNATURE OF JURY | | 32. SIGNATURE OF JURY | | 33. SIGNATURE OF JURY | |
| 34. SIGNATURE OF JURY | | 35. SIGNATURE OF JURY | | 36. SIGNATURE OF JURY | |
| 37. SIGNATURE OF JURY | | 38. SIGNATURE OF JURY | | 39. SIGNATURE OF JURY | |
| 40. SIGNATURE OF JURY | | 41. SIGNATURE OF JURY | | 42. SIGNATURE OF JURY | |
| 43. SIGNATURE OF JURY | | 44. SIGNATURE OF JURY | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF JURY | | 47. SIGNATURE OF JURY | | 48. SIGNATURE OF JURY | |
| 49. SIGNATURE OF JURY | | 50. SIGNATURE OF JURY | | 51. SIGNATURE OF JURY | |
| 52. SIGNATURE OF JURY | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF JURY | |
| 55. SIGNATURE OF JURY | | 56. SIGNATURE OF JURY | | 57. SIGNATURE OF JURY | |
| 58. SIGNATURE OF JURY | | 59. SIGNATURE OF JURY | | 60. SIGNATURE OF JURY | |
| 61. SIGNATURE OF JURY | | 62. SIGNATURE OF JURY | | 63. SIGNATURE OF JURY | |
| 64. SIGNATURE OF JURY | | 65. SIGNATURE OF JURY | | 66. SIGNATURE OF JURY | |
| 67. SIGNATURE OF JURY | | 68. SIGNATURE OF JURY | | 69. SIGNATURE OF JURY | |
| 70. SIGNATURE OF JURY | | 71. SIGNATURE OF JURY | | 72. SIGNATURE OF JURY | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JURY | | 75. SIGNATURE OF JURY | |
| 76. SIGNATURE OF JURY | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF JURY | |
| 79. SIGNATURE OF JURY | | 80. SIGNATURE OF JURY | | 81. SIGNATURE OF JURY | |
| 82. SIGNATURE OF JURY | | 83. SIGNATURE OF JURY | | 84. SIGNATURE OF JURY | |
| 85. SIGNATURE OF JURY | | 86. SIGNATURE OF JURY | | 87. SIGNATURE OF JURY | |
| 88. SIGNATURE OF JURY | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF JURY | | 92. SIGNATURE OF JURY | | 93. SIGNATURE OF JURY | |
| 94. SIGNATURE OF JURY | | 95. SIGNATURE OF JURY | | 96. SIGNATURE OF JURY | |
| 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JURY | | 99. SIGNATURE OF JURY | |
| 100. SIGNATURE OF JURY | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JURY | |

RECEIVED
OCT 15 1957
BUREAU V. 2

10227

CERTIFICATE OF DEATH

10206

Reg. Dist. No. 3

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE _____ b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Laurel | | c. LENGTH OF STAY IN 1b
5 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. <u>47x-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Children's District Training School, Center, Laurel, Md. | | | | d. STREET ADDRESS
517 - 16th Street, S.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Karen Middle Lee Last Krivak | | | 4. DATE OF DEATH
Month October Day 6 Year 19 57 | | | | |
| 5. SEX
F | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/13/46 | | 9. AGE (In years lost birthday)
10 yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
Louis Krivak | | | | 14. MOTHER'S MAIDEN NAME
Mildred Kulin Krivak | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Address Children's Center District Training School, Laurel, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration Pneumonia
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) convulsive disorder
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hours |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | |
| | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | |
| 21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>October</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 4</u> , 19 <u>57</u> , and that death occurred at <u>12:45 A.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut, M.D.</u>
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut, M.D.</u> <u>Children's Center, Laurel, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 22b. DATE THEREOF
<u>10/9/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>D.T. School</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Laurel, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____ | | | | 24a. REC'D BY REGISTRAR _____ 24b. REGISTRAR'S SIGNATURE _____
DATE <u>10/2/57</u> <u>Helena H. Moscup</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

| | | | | | | | | | |
|------------------------|--|----------------------|--|-----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1922 | | MOBILE, ALABAMA | |
| RACE | | COLOR | | EDUCATION | | OCCUPATION | | MANNER OF DEATH | |
| WHITE | | WHITE | | HIGH SCHOOL | | CONTRACTOR | | SUICIDE | |
| RELIGION | | MARITAL STATUS | | PREVIOUS ILLNESS | | CAUSE OF DEATH | | PLACE OF DEATH | |
| METHODIST | | MARRIED | | NONE | | HEART DISEASE | | AT HOME | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CERTIFICATE NO. | | REGISTERED | |
| JAN 15 1957 | | 10:00 PM | | AT HOME | | 12345 | | YES | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF REGISTRAR | |
| J. H. SMITH | | J. H. SMITH | | J. H. SMITH | | J. H. SMITH | | J. H. SMITH | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 15 1957 | | JAN 15 1957 | | JAN 15 1957 | | JAN 15 1957 | | JAN 15 1957 | |

RECEIVED
NOV 5 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10166 CERTIFICATE OF DEATH

10207

Reg. Dist. No. 21

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Anne Arundel</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>A. A. Co.</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Annapolis P.O.</i> | | | |
| 3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i> | | | | d. STREET ADDRESS <i>Rt 2 Box 96</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>WILLIAM H. LANGLEY</i> | | | | 4. DATE OF DEATH Month <i>10</i> Day <i>23</i> Year <i>1957</i> | | | |
| 5. SEX <i>M</i> | | 6. COLOR OR RACE <i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>8/27/07</i> | |
| 9. AGE (In years last birthday) <i>50</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction, Camp George Meade</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Oil City, Penna</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>USA</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>Elmer Langley</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary H.</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>227-03-6341</i> | | | |
| 17. INFORMANT <i>Mrs. Emeline H. Langley, same</i> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> | | | | <i>10 days</i> | | | |
| DUE TO <i>Arteriosclerotic C.V. Disease</i> | | | | <i>2 yrs +</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>10/14/1957</i> to <i>10/23/1957</i> , that I last saw the deceased alive on <i>10/23/1957</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Maurice F. Klawans</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>Annapolis, Md</i> DATE SIGNED <i>10/24/57</i> | | | |
| PHYSICIAN'S NAME (Type) <i>MAURICE F. KLA WANS</i> | | | | <i>31 Smith Ave</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>10/25/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> | | | | 24a. REC'D BY REGISTRAR <i>OC</i> DATE <i>28 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>Wm J. French</i> | |

RECEIVED

BUREAU V. S.

02128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10208
 10167 CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. LENGTH OF STAY IN 1b
63 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
MAHLON LOWMAN JR. | | | | 4. DATE OF DEATH
Month Day Year
OCTOBER 18 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 7 1917 | |
| 9. AGE (In years last birthday)
40 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Grain Operator | | 11. BIRTHPLACE (State or foreign country)
Waterbury, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Mahlon Lowman Sr. | | | | 14. MOTHER'S MAIDEN NAME
Rosa Lowman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
212-12-4612 | | 17. INFORMANT
Mrs. Emma Lowman - Wife - Crownsville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage
DUE TO
330X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hypertensive cardiovascular disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 hrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/18 , 19 57 , to 10/18 , 19 57 , that I last saw the deceased alive on 10/18 , 19 57 , and that death occurred at 9 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED 10/19/57 | | | | | | | |
| ACTUAL SIGNATURE John C. Hedeman M.D. | | | | PHYSICIAN'S NAME (Type) John Hedeman M.D. Annapolis, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 22, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Baldwin Memorial Cem. | | 22d. LOCATION (City, town, or county) (State)
Millersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
HOPPING FUNERAL HOME Annapolis, Md. | | | | 24a. REC'D BY REGISTRAR
OCT 22 1957 | | 24b. REGISTRAR'S SIGNATURE
Thm. J. Henchy | |

OCT 22 1957

BUREAU V. 5

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10209

10168

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>aa</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>aa</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General</u> | | d. STREET ADDRESS <u>139 Murrays Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>N.</u> Last <u>Lyons</u> | | 4. DATE OF DEATH Month <u>10</u> - Day <u>29</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-4-1893</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William W. Russell</u> | | 14. MOTHER'S MAIDEN NAME <u>Carrie Norfolk</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Douglas F Lyons</u> | |
| 17. INFORMANT <u>248 Main St. Annapolis Md</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>
10 YRS
INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PREVIOUS MYOCARDIAL INFARCTION</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11-1-57</u> , 19 <u>57</u> , to <u>30 OCT</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>30 OCT</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward A Beck</u> | | ADDRESS (Street, city or town, state) <u>4 Southgate Ave, Annapolis 1957</u> | |
| DATE SIGNED <u>11/1/57</u> | | M.D. <u>H. Southgate Ave, Annapolis 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>John M. Taylor Sr</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-1-57</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> | | 24a. REC'D BY REGISTRAR <u>11/1/57</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. D. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10210

10169

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. LENGTH OF STAY IN 1b
1 Day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S.N. Hospital, Annapolis, Maryland | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Alexander S. Last MACKLIN | | | | 4. DATE OF DEATH
Month Oct Day 5 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Cau | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
23 July 1897 | |
| 9. AGE (In years last birthday) yrs.
60 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S.Navy | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S.Navy | | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Charles F. MACKLIN | | | | 14. MOTHER'S MAIDEN NAME
Emily STEWART | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes (If yes, give war or dates of service)
WWI & WW II | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT
U.S.N. Hospital, Annapolis, Maryland | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA, STOMACH WITH METASTASIS
151X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
One year |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5 October, 19 57 , to 5 October, 19 57 , that I last saw the deceased alive on 5 October, 19 57 , and that death occurred at 9:20P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
U.S.N. Hospital, Annapolis, Md. 10-6-57 | | | | | | | |
| ACTUAL SIGNATURE Robert J. Busse Jr. | | | | M.D. U.S.N. Hospital, Annapolis, Md. 10-6-57 | | | |
| PHYSICIAN'S NAME (Type) Robert J. BUSSE Jr. | | | | LT MC USNR | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 10-8-1957 | | ARLINGTON NAT'L | | ARLINGTON VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Taylor & Sons | | | | ADDRESS
Annapolis, Md. | | 24a. REC'D BY REGISTRAR
10/8/57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
U. D. Smith | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V.B.

OCT 10 1957

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10211

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Ann Arundel</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seyvern, Md</u>
c. LENGTH OF STAY IN lb <u>Few minutes</u> <u>Ft Meade Md</u> <u>X 2</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Ft Meade Md</u> b. COUNTY <u>Ann Arundel</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Ft Meade Md</u> <u>X 2</u>
d. STREET ADDRESS <u>1</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>DAVID</u> First <u>SP3</u> Middle <u>E</u> Last <u>RA13539422</u> <u>MAKAVICKAS</u>
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cau</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>20 Jul 1937</u>
9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | | | 4. DATE OF DEATH <u>October</u> <u>9</u> <u>1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>ARMY</u>
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Edward Makavickas</u>
14. MOTHER'S MAIDEN NAME <u>Dorothy Richards</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT <u>Edward Makavickas, 621 5th Ave. McKeesport, Pa.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture of skull, fracture of mandible and multiple lacerations of face</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>823X</u> DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident hit a post</u>
20c. TIME OF INJURY Month, Day, Year <u>9 Oct. 1957</u> Hour <u>1130</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 170 Seyvern Md</u>
20f. (City or town) (County) (State) <u>Ann Arundel County</u> | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) <u>GUSTAVE H FAUBERT, MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9 October 1957</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Oct. 14, 1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>McKeesport, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u> 24a. REC'D BY REGISTRAR <u>10 Oct 57</u> 24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MSC</u> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10212

10229

CERTIFICATE OF DEATH

Reg. Dist. No.

24

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | | | c. LENGTH OF STAY IN 1b <u>3 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gov. Ritchie Hwy. Robinson Road</u> | | | | d. STREET ADDRESS <u>Gov. Ritchie Hwy. Robinson Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>G.</u> Last <u>MANNION</u> | | | | 4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>11</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 10, 1889</u> | |
| 9. AGE (In years last birthday) <u>68</u> | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ins. & R. Est. Broker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Mannion</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cecelia Gold</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>--</u> | | | | 16. SOCIAL SECURITY NO. <u>219-32-0100</u> | | 17. INFORMANT Address <u>Mrs. Nellie V. Mannion Same As #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Oct. 1</u> , 1957, to <u>Oct. 11</u> , 1957, that I last saw the deceased alive on <u>Oct. 11</u> , 1957, and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u> | | | | | | | |
| ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D. <u>Francis I. Codd M.D.</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u></u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 15/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Brooklyn BFD. Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Single</u> ADDRESS <u>Glen Burnie, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>16</u> DATE <u>1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Sealy</u> | |

CERTIFICATE OF DEATH

10520

BUREAU V. 3

OCT 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10213
10170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. *31*

| | | | | | |
|---|---------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY <i>Anne Arundel</i> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>City Dump</i> | | | d. STREET ADDRESS
<i>14 Johnson St.</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <i>Joseph</i> First Middle Last | | | 4. DATE OF DEATH
Month <i>10</i> Day <i>12</i> Year <i>1957</i> | | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>Col.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>3-15-1919</i> | | 9. AGE (In years to birthday)
yrs. <i>8</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>School Boy</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Shadensburg, Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 13. FATHER'S NAME
<i>James Mason</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Bessie Green</i> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes or no) <i>No</i> | | |
| 16. SOCIAL SECURITY NO.
<i>—</i> | | | 17. INFORMANT
Name <i>James Mason - Anna, Md.</i> Address <i>—</i> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Internal Injuries</i>
 <i>910.8</i> DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
 DUE TO (c)
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </p></div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH
<i>Instant</i></p> </div> </div> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>metal crabs fell on child while playing</i> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<i>Nov. 10-12 1957</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>garage yard</i> | |
| 20f. (City or town)
<i>Annapolis</i> | | 20g. (County)
<i>Anne Arundel</i> | | 20h. (State)
<i>Md.</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <i>E. Linhardt</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>10-15-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Shadensburg Md.</i> | |
| 22d. LOCATION (City, town, or county)
<i>Shadensburg Md.</i> | | 22e. (State)
<i>Md.</i> | | 24a. REC'D BY REGISTRAR
DATE <i>10/14/57</i> | |
| 24b. REGISTRAR'S SIGNATURE
<i>Wm. J. Lush</i> | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

The
 James M. Mason
 Robert B. Lee
 Male Col.
 170254
 City of New York
 (Inverted)
 James M. Mason

BUREAU V. S.

RECEIVED

For production

12-21-01
C. Williams
W. Williams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10214

10230

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore <i>a.d.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Linthicum Heights | | c. LENGTH OF STAY IN 1b
4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
100 East Hammond Ferry Road | | d. STREET ADDRESS
07x2.2 | |
| 3. NAME OF DECEASED (Type or print)
First Bertha Middle P. Last McKinney | | 4. DATE OF DEATH
Month 10 Day 18 Year 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 28 1878 |
| 9. AGE (In years last birthday) yrs.
79 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Isaach Payne | | 14. MOTHER'S MAIDEN NAME
Mary A. Dewberry | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
J. Evans McKinney | | Address
Blkton, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
24 hrs.
2 yr + | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Oct 17 , 19 57 , to Oct 18 , 19 57 , that I last saw the deceased alive on Oct 18 , 19 57 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
C. Milton Linthicum | | ADDRESS (Street, city or town, state)
106 W. Maple Rd. Linthicum Heights, Md. | |
| PHYSICIAN'S NAME (Type)
C. Milton Linthicum | | DATE SIGNED
10/18/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-22-1957 | 22c. NAME OF CEMETERY OR CREMATORY
Bethel | 22d. LOCATION (City, town, or county) (State)
Chesapeake City, Cecil, Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph R. Grant | | ADDRESS
North East, Maryland | |
| 24a. REC'D BY REGISTRAR
DATE 21 1957 | | 24b. REGISTRAR'S SIGNATURE
Dr. G. M. Linthicum | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10215

10171 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>AA</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General</u> | | d. STREET ADDRESS <u>15 Locust Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Leech</u> Last <u>Medford</u> | | 4. DATE OF DEATH Month <u>10</u> - Day <u>7</u> - Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 17-1869</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - U.S.N.A.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk Med. Store</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Henry Medford</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Ann Lewis</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Mrs William Clatanoff</u> | | Address <u>1006 Beach St Annapolis Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO
(b) <u>General arteriosclerosis</u>
DUE TO
(c) <u>General arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
<u>yes.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 7, 1957</u> , to <u>Oct 7, 1957</u> , that I last saw the deceased alive on <u>Oct 7, 1957</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D. | | ADDRESS (Street, city or town, state) <u>31 Smith St W</u> DATE SIGNED <u>10/8/57</u> | |
| PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAUANS</u> | | <u>Annapolis, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-9-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>10/10/57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>V. Ormrod</u> | |

14 OCT 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10172

CERTIFICATE OF DEATH

Reg. Dist. No.

10216

| | | | |
|--|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | c. LENGTH OF STAY IN 1b
<u>1 Day</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S.N. Hospital, Annapolis, Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Stanley</u> Middle <u>William</u> Last <u>MILLER</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>7</u> Year <u>19 57</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6 Oct 1957</u> |
| 9. AGE (In years last birthday)
— — yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
— — — — — | | 10b. KIND OF BUSINESS OR INDUSTRY
— — — — — | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>William Stanley MILLER</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annelle Huddleston NORTH</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
— — — — — | | 16. SOCIAL SECURITY NO.
— — — — — | |
| 17. INFORMANT
<u>U.S.N. Hospital, Annapolis, Maryland</u> | | Address | |

| | | |
|---|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
7544 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cor triloculare and biventriculare</u>
DUE TO
(c) <u>Prematurity</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 Hours</u>
<u>9 Hrs.15Min</u>
<u>9 Hrs.15Min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) |
| 21. I certify that I attended the deceased from <u>6 October</u> , 19 <u>57</u> , to <u>7 October</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 October</u> , 19 <u>57</u> , and that death occurred at <u>3:15 A</u> .M., from the causes and on the date stated above. | | |
| ACTUAL SIGNATURE <u>H. M. Kravitz</u> | | DATE SIGNED <u>10-7-57</u> |
| PHYSICIAN'S NAME (Type) <u>H. M. KRAVITZ</u> | | ADDRESS (Street, city or town, state) <u>U.S.N.Hosp. Annapolis, Md.</u> |
| M.D. <u>LT MC USNR</u> | | |

| | | | |
|--|---------------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>10-8-1957</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>U.S. NAVAL ACADEMY</u> | 22d. LOCATION (City, town, or county) (State)
<u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Taylor + sons</u> | | 24. REC'D BY REGISTRAR
<u>10/8/57</u> | |
| ADDRESS
<u>Annapolis, Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>V. V. V. V.</u> | |

CERTIFICATE OF DEATH

10773

| | | | | | |
|------------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | |
| DATE OF BIRTH | | PLACE OF BIRTH | | CITY | |
| FATHER'S NAME | | MOTHER'S NAME | | MARRIAGE DATE | |
| EDUCATION | | RELIGION | | RACE | |
| PREVIOUS ILLNESS | | HISTORY OF DEATH | | HISTORY OF LIFE | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF WITNESSES | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |

RECEIVED
OCT 10 1957
BUREAU V. S.

10231

CERTIFICATE OF DEATH

10217

Reg. Dist. No.

| | | | |
|--|-----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>A. A.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorchester</u> | | c. LENGTH OF STAY IN 1b <u>10 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Kent</u> First <u>Barbada</u> Middle <u>Osborne</u> Last | | 4. DATE OF DEATH <u>Oct</u> Month <u>18</u> Day <u>1957</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 12 1908</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Sutherland Ga</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Osborne</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Osborn</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Charles Edmonds</u> | |
| 17. INFORMANT <u>Charles Edmonds</u> Address <u>Dorchester</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>Oct 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 17</u> , 19 <u>57</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward G. Bennett</u> | | DATE SIGNED <u>10-19-57</u> | |
| PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 21 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Osborne</u> | | 22d. LOCATION (City, town, or county) (State) <u>Sutherland Ga</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson</u> ADDRESS <u>Amesbury Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 22 '57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u> | |

BUREAU V. S.

OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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VS. A15ME
5M 2/57

10232

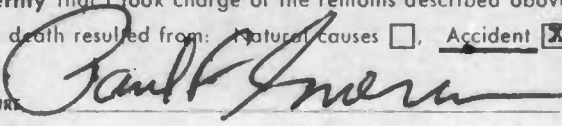

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10218

Item 20-c, Film G-224 -1/10/58.cac

Reg. Dist. No.

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Near Pig Point | | c. LENGTH OF STAY IN 1b
Washington 47 x 3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
518 Quincy Street, N.W. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle D. Last PAYNE | | 4. DATE OF DEATH
Month October Day 30 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 30, 1920 |
| 9. AGE (In years last birthday)
37 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Gov't. Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Gov't. | |
| 11. BIRTHPLACE (State or foreign country)
Heathsville, Va. | | 12. CITIZEN OF WHAT COUNTRY
U. S. A. | |
| 13. FATHER'S NAME
Daniel Payne | | 14. MOTHER'S MAIDEN NAME
Edwina Thompson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
5/7/43-11/25/45 | |
| 17. INFORMANT
Mrs. Marion Payne | | Address
518 Quincy St., N. W. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning.
850X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fell out of boat. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell out of boat. | |
| 20c. TIME OF INJURY
Month, Day, Year
About 2:00 p.m. 10/26/57 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Patuxent River | | 20f. (City or town) (County) (State)
Pig Point A.A. Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
 | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Paul F. Guerin, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
10/31/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-4-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John T. Rhines & Co. | | 24a. REC'D BY REGISTRAR
NOV 4 '57 | |
| ADDRESS
901 3rd St., S. W. | | 24b. REGISTRAR'S SIGNATURE
 | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of Health

Section

John Doe

1000 North Street

1000 North Street

1000 North Street

1000 North Street

BUREAU V. 2

NOV 4 1957

RECEIVED

John Doe

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10173

CERTIFICATE OF DEATH

10219

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>AA</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ANNAPOLIS</u> | | c. LENGTH OF STAY IN 1b
<u>1 day</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>ANNE ARUNDEL General</u> | | d. STREET ADDRESS
<u>TRACYS Landing Md. x0</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>VERA</u> Middle <u>PEMBROKE</u> Last <u>PEMBROKE</u> | | 4. DATE OF DEATH
Month <u>OCT</u> Day <u>20</u> Year <u>1957</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov 10 1886</u> |
| 9. AGE (In years last birthday)
<u>70</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Hartshamville W. VA</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Hartshamville W. VA</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>WINTON M. NITISER</u> | | 14. MOTHER'S MAIDEN NAME
<u>Fustoid Weems Nitisier</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<input type="checkbox"/> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<input type="checkbox"/> | |
| 17. INFORMANT
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Corborevascular accident</u>
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerosis, generalized</u>
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs</u>
<u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>57</u> , to <u>10/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>57</u> , and that death occurred at <u>5:05</u> P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED <u>10/20/57</u> | | | |
| ACTUAL SIGNATURE <u>John H. Hederman</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>OCT 22/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>ST MARKS</u> | | 22d. LOCATION (City, town, or county) (State)
<u>DEALE MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Bernard Hurduty Galisville Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>10/24/57</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

RECEIVED

10233 CERTIFICATE OF DEATH

Reg. Dist. No. 54

| | | | | | | | |
|---|-------------------|---|---------------------|---|-----------------|---|----------------------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Carroll</i> | | MARYLAND | | STATE <i>Md.</i> | | COUNTY <i>Carroll</i> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| TOWN <i>Hagerstown</i> | | <i>7 yrs.</i> | | TOWN <i>same</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <i>1412 2nd Rd.</i> | | | | <i>same</i> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE OF DEATH: (Month) (Day) (Year) | | | |
| <i>THOMAS HARRY PENN</i> | | | | <i>Oct 12 1957</i> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <i>M</i> | <i>W</i> | <i>Married</i> | <i>27 Feb. 1883</i> | <i>74 yrs.</i> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Gen'l. Passgr. Agt.</i> | | <i>Steamship Co.</i> | | <i>Camp Chapel, Md.</i> | | <i>U.S.A.</i> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <i>James Penn (dec.)</i> | | | | <i>Eliz. Nichols (dec.)</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | |
| <i>no</i> | | | | <i>215-07-5404</i> | | <i>Miss Lillian Penn - Wife. 1412 2nd Rd. Hagerstown, Md.</i> | |
| 18. MEDICAL CERTIFICATION | | | | | | | Interval Between Onset and Death |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 331X Immediate cause (a) <i>Myocarditis</i> | | | | | | | <i>1 day</i> |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Cerebral Vascular Accident</i> | | | | | | | <i>10 days</i> |
| (c) <i>Hypertension</i> | | | | | | | <i>10 yrs.</i> |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>arteriosclerosis, generalized</i> | | | | | | | <i>10 yrs.</i> |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| <i>none</i> | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| <i>None</i> | | <i>Office bldg.</i> | | | | | |
| TIME (Month) (Day) (Year) (Hour) | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 19....., to <i>12 Oct.</i> , 19 <i>57</i> , that I last saw the deceased alive on 19....., and that death occurred at <i>2:55 PM</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE (Degree or title) | | | | ADDRESS DATE SIGNED | | | |
| <i>H-F. Manuzak M.D.</i> | | | | <i>901 Edgerly Rd. Hagerstown 12 Oct 57</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>10/15/57</i> | | <i>Reisterstown Meth. Cem.</i> | | <i>Reisterstown, Md.</i> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <i>10/14/57</i> | | <i>L. Health</i> | | <i>Wm. J. Vickers & Sons</i> | | <i>Balto 17</i> | |

*Note - Regular patient of Dr. Pritchard.**Md*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly. age is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU V. S.

OCT 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G22211-14-57 et

10234

CERTIFICATE OF DEATH

102212

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Laurel, Md. | | | | c. LENGTH OF STAY IN 1b
14 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Children's District Training School, Center, Laurel, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Roselle Middle Taylor Last Pickrel | | | | 4. DATE OF DEATH
Month October Day 28 Year 1957 | | | |
| 5. SEX M | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 6, 1936 | |
| 9. AGE (In years last birthday)
21 yrs. | | IF UNDER 1 YEAR
Months 21 Days 28 Hours 1957 | | IF UNDER 24 HRS.
Months 21 Days 28 Hours 1957 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
-- | | | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | | | |
| 11. BIRTHPLACE (State or foreign country)
Jersey City, N.J. | | | | 12. CITIZEN OF WHAT COUNTRY?
US | | | |
| 13. FATHER'S NAME
Roselle Pickrel | | | | 14. MOTHER'S MAIDEN NAME
Helen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
-- | | | | 17. INFORMANT
Children's District Training School, Center, Laurel, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c) 491X
INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency secondary to cerebral injury at birth | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 a. m. 19 p. m. | | | | | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from August , 19 56 , to October , 19 57 , that I last saw the deceased alive on October 25 , 19 57 , and that death occurred at 4:55 A.M. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 10/28/57 | | | | | | | |
| ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 10/31/57 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) Washington D.C. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mathingly ADDRESS Wash D.C. | | | | | | | |
| 24a. REC'D BY REGISTRAR 10/28/57 24b. REGISTRAR'S SIGNATURE Adara W. Carbutt | | | | | | | |

CERTIFICATE OF DEATH

10851

MARYLAND STATE DEPARTMENT OF HEALTH-CALCULATED

10851

BUREAU V. 3

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10174

CERTIFICATE OF DEATH

10222

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>AA</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA General</u> | | d. STREET ADDRESS <u>15 Cornhill</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>George Dorsey Rawlings</u> | | 4. DATE OF DEATH Month Day Year <u>10 - 19 1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-6-1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <u>Watchman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Annapolis Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>William J. Rawlings</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Schiele</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>If yes, give war or dates of service</u> | | 16. SOCIAL SECURITY NO. <u>Catherine E. Fisher</u> | |
| 17. INFORMANT Address <u>(2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u>
DUE TO <u>Emphysema</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yrs</u>
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>March, 1953</u> , to <u>10/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>57</u> , and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>10/20/57</u>
DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>John L. H. Druman</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-22-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u> | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md.</u> | | 24a. REC'D BY REGISTRAR <u>10/22/57</u> | 24b. REGISTRAR'S SIGNATURE <u>10/22/57</u> |

BUREAU V. S.

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10235

CERTIFICATE OF DEATH

102238
 Reg. Dist. No.

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
7 ys, 1 mo, 8 ds. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 3. NAME OF DECEASED (Type or print)
First Mamie Middle Rich Last Rich | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | d. STREET ADDRESS
805 Rutland Ave. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4. DATE OF DEATH
Month 10 Day 20 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Unknown |
| 9. AGE (In years last birthday)
63? | | IF UNDER 1 YEAR
Months 63? Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Bracheson Rich | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) -----
(If yes, give war or dates of service) ----- | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Hospital Records | | Address
----- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia
DUE TO (b) 490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) -----
DUE TO (b) -----
DUE TO (c) -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, Mixed Type
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
INTERVAL BETWEEN ONSET AND DEATH
few days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
----- | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. ----- p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State)
----- | |
| 21. I certify that I attended the deceased from September 12, 1950 , to October 20, 1957 , that I last saw the deceased alive on October 20, 1957 , and that death occurred at 6:00 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Lionel McHenry Mapp | | DATE SIGNED
10/21/57 | |
| PHYSICIAN'S NAME (Type)
Lionel McHenry Mapp, M. D. | | ADDRESS (Street, city or town, state)
Crownsville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/25/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary | | 22d. LOCATION (City, town, or county) (State)
Balt. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C. O. Wilson | | 24a. REC'D BY REGISTRAR
10/29/57 | |
| ADDRESS
2004 Orleans St. | | 24b. REGISTRAR'S SIGNATURE
K. M. Joyce | |

CERTIFICATE OF DEATH

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|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. PLACE OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF REGISTRAR | | 13. SIGNATURE OF PHYSICIAN | | 14. SIGNATURE OF CLERK | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10224

10236

CERTIFICATE OF DEATH

Reg. Dist. No.

28

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
4 ys, 2 mos, 25 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 3. NAME OF DECEASED (Type or print)
First Josie Middle Ella Last Richardson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Crownsville State Hospital, Md. | | d. STREET ADDRESS
1119 N. Caroline St. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4. DATE OF DEATH
Month 10 Day 8 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/12/1882 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
South Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Isam Hayler | | 14. MOTHER'S MAIDEN NAME
Anna H. Nuckles | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) -----
(If yes, give war or dates of service) ----- | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
450.0 DUE TO
Generalized Arteriosclerosis
since admission
7/13/53
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. ft. p. m. ----- 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | 20f. (City or town) (County) (State)
----- |
| 21. I certify that I attended the deceased from 7/13 , 19 53 , to 10/8 , 19 57 , that I last saw the deceased alive on 10/8 , 19 57 , and that death occurred at 2:25 a.m., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>L. Benedict</i> | | ADDRESS (Street, city or town, state)
Crownsville, Md. | |
| PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | DATE SIGNED
10/8/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/12/57 | 22c. NAME OF CEMETERY OR CREMATORY
1817A CEM. |
| 22d. LOCATION (City, town, or county) (State)
1817A S.C. | | 10/8/57 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Randolph Collick</i> | | 24. REC'D BY REGISTRAR
10/14/57 | |
| ADDRESS
-1412 PRESTON ST | | 24b. REGISTRAR'S SIGNATURE
<i>J. M. Joyce</i> | |

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10225

10175

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|---------------------------------------|---|---------------------------|---|---------|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis 10 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S.N. Hospital, Annapolis, Maryland | | | | d. STREET ADDRESS
107 Severn Avenue | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Bert Middle John Last RINNESS | | | | 4. DATE OF DEATH
Month October Day 6 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9 Sep 1886 | 9. AGE (In years last birthday)
71 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Navy | | 11. BIRTHPLACE (State or foreign country)
Michigan | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George RINNESS | | | | 14. MOTHER'S MAIDEN NAME
Julia BONNEWITZ | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
213-22-0802 | | 17. INFORMANT
U.S.N. Hospital, Annapolis, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hematoma, subdural left parietal region
331X
DUE TO cause spontaneous
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebral Edema | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour 19 Month, Day, Year | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from 6 October , 19 57 , to 6 October , 19 57 , that I last saw the deceased alive on 6 October , 19 57 , and that death occurred at 4:35 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE J. W. McRoberts M.D. U.S.N. Hospital, Annapolis, Md. 7 Oct 1957
PHYSICIAN'S NAME (Type) J. W. MCROBERTS LT MC USNR | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10-9-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Annapolis National | | 22d. LOCATION (City, town, or county) (State)
Annapolis Mo. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Toyle & Sons | | | | 24a. REC'D BY REGISTRAR
10/8/57 | | 24b. REGISTRAR'S SIGNATURE
J. J. French | |

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED
OCT 10 1957
BUREAU V. B.

10237

CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | |
|--|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Sup. Est. Kent. Pasadena B.V. MARYLAND</i> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Same</i> b. COUNTY <i>A.A.</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural - Pasadena Md</i> | | c. LENGTH OF STAY IN 1b
<i>34 years</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>2222 Pasadena Md.</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>—</i> | | | d. STREET ADDRESS
<i>1</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <i>Rosetta</i> Middle <i>Madelin</i> Last <i>Roberts</i> | | | 4. DATE OF DEATH
Month <i>October</i> Day <i>18</i> Year <i>1957</i> | | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Sept 24, 1880</i> | 9. AGE (In years last birthday)
<i>77</i> yrs. | IF UNDER 1 YEAR
Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>at home</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore Md.</i> | |
| 13. FATHER'S NAME
<i>Richard Roberts</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Laura Jane Mathanay</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>no</i> | | 17. INFORMANT
<i>Mrs. Lucie Van Meter - Pasadena Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>
<i>422.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardio-vascular Disease</i>
DUE TO (c) <i>—</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>10 years</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>none</i> | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>—</i> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <i>—</i> a. m. <i>—</i> p. m. <i>19</i> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>—</i> | |
| | | 20f. (City or town)
<i>—</i> | | (County) <i>—</i> (State) <i>—</i> | |
| 21. I certify that I attended the deceased from <i>10 years</i> , 19 <i>—</i> , to <i>—</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>Oct 17</i> , 19 <i>57</i> , and that death occurred at <i>5:10 A.M.</i> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <i>James S. Billingsley</i> | | | ADDRESS (Street, city or town, state) <i>10 P Central Ave. Baltimore Md</i> | | |
| PHYSICIAN'S NAME (Type) <i>James S. Billingsley MD</i> | | | DATE SIGNED <i>Oct 19, 1957</i> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>Oct. 24, 1957</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Baltimore Cem.</i> | |
| | | 22d. LOCATION (City, town, or county)
<i>Balto Md.</i> | | (State) <i>—</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>R. J. Kingston</i> | | | 24a. REC'D BY REGISTRAR
<i>—</i> | | 24b. REGISTRAR'S SIGNATURE
<i>L. J. Adallay</i> |
| | | | DATE
<i>OCT 23 1957</i> | | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1957

BUREAU V. 8

OCT 23 1957

RECEIVED

10176

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b
10 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | d. STREET ADDRESS
159 Prince George Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HELEN Middle A Last RUSTEBERG | | 4. DATE OF DEATH
Month OCTOBER Day 27 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 9, 1885 |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (State or foreign country)
Annapolis, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John W. Anderson | | 14. MOTHER'S MAIDEN NAME
Florence Blackburn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
218-03-9204B | |
| 17. INFORMANT
Mr Charles A. Rusteberg- Husband- same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
422.1 DUE TO
(b) Arteriosclerotic C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2600 DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes M. to Coma
INTERVAL BETWEEN ONSET AND DEATH
1 hr.
— | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb , 19 58 , to 10-27- , 19 57 , that I last saw the deceased alive on 10-27-57 , 19 57 , and that death occurred at 1 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 10-28-57 | | | |
| ACTUAL SIGNATURE Frank M Shipley M.D. | | | |
| PHYSICIAN'S NAME (Type) Frank Shipley | | 63 College Ave Annapolis, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Oct. 29, 1957 | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Bluff Cemetery | 22d. LOCATION (City, town, or county) (State)
Annapolis, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | ADDRESS
Annapolis, Md. | |
| 24a. REC'D BY REGISTRAR
OCT 30 1957 | | 24b. REGISTRAR'S SIGNATURE
Am J. Knecht | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH - BALTIMORE 18

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10177

CERTIFICATE OF DEATH

10228

Reg. Dist. No. 21

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
10 Annapolis, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
96 Market Street | | d. STREET ADDRESS
96 Market Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First WILLIAM Middle H Last SANDERS | | 4. DATE OF DEATH
Month OCTOBER Day 8 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 5, 1867 |
| 9. AGE (In years last birthday)
90 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Sea Captian | | 10b. KIND OF BUSINESS OR INDUSTRY
State of Maryland | |
| 11. BIRTHPLACE (State or foreign country)
Annapolis, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Daniel Wheeler Sanders | | 14. MOTHER'S MAIDEN NAME
Mayy Heaver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Family records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular Failure
154X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cancer of Rectum
DUE TO
(c) General Arterio Sclerosis + Hypertension | | INTERVAL BETWEEN ONSET AND DEATH
Several Days
Many Months
Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 6th , 19 57 , to Oct 8 , 19 57 , that I last saw the deceased alive on 10-7- , 19 57 , and that death occurred at 6:30 M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
J. Oliver Purvis | | ADDRESS (Street, city or town, state)
40 Franklin St. Annapolis Md | |
| DATE SIGNED
10/9/57 | | | |
| PHYSICIAN'S NAME (Type)
J. Oliver Purvis MD | | 40 Franklin Street, Annapolis, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 10, 57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Anne's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Annapolis, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | ADDRESS
Annapolis, Md. | |
| 24a. REC'D BY REGISTRAR
DATE | | 24b. REGISTRAR'S SIGNATURE
11 19 57 | |

RECEIVED

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The ~~1~~ copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10229

10178

Reg. Dist. No. 21

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Anne Arundel</i> | MARYLAND | STATE <i>Maryland</i> | COUNTY <i>Anne Arundel</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <i>Annapolis</i> | LENGTH OF STAY
(In this place) | CITY OR TOWN <i>Gambrells</i> | (If rural give location) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<i>Anne Arundel General Hospital</i> | | STREET ADDRESS
<i>1</i> | |
| 3. NAME OF DECEASED
(Type or Print) <i>Alpheus F. Sanner, Sr.</i> | | 4. DATE OF DEATH
(Month) <i>Oct.</i> (Day) <i>2</i> (Year) <i>1957</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED
(Specify) <i>Married</i> | 8. DATE OF BIRTH
<i>May 6, 1880</i> |
| 9. AGE last birthday
<i>77</i> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Cab. Maker (ret.)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Balto. Md. Ice Co.</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>St. Marys Co., Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Richard Sanner</i> | | 14. MOTHER'S MAIDEN NAME
<i>Nancy Jones</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>None</i> | |
| 17. INFORMANT & ADDRESS
<i>Mr. Elizabeth Sanner - Same As #2</i> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
<i>332X</i> IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2-4 wks.</i> | |
| ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
<i>Influenza 481X</i> | | <i>6 wks.</i> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>9-26, 1957</i> , to <i>10-2, 1957</i> , that I last saw the deceased alive on <i>10-2, 1957</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above. | | | |
| SIGNATURE
<i>Frank M. Shipley</i> | | ADDRESS (Street, city, town, state)
<i>M.D. 63 College Ave, Annapolis, Md.</i> | |
| DATE
<i>Oct. 5, 1957</i> | | DATE SIGNED
<i>10-2-57</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 24. REC'D BY REGISTRAR
<i>Oct. 5, 1957</i> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE
<i>Richard P. Long</i> | | 26. ADDRESS
<i>Glenn Burnie, Md.</i> | |

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lake Shore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
XO Lake Shore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Lake Shore Drive | | d. STREET ADDRESS
1 Lake Shore Drive | |
| 3. NAME OF DECEASED (Type or print)
First BERTHA Middle SCHRODETZKI Last SCHRODETZKI | | 4. DATE OF DEATH
Month Oct. Day 4 Year 19 57 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/23/1856 |
| 9. AGE (In years last birthday)
100 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
? Martin | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
no | |
| 17. INFORMANT
Mrs. Lillian Hammerbacher - Lake Shore, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute pulmonary edema
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardio-vascular disease
DUE TO (c) 2 yrs. | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month, Day, Year
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from October 1, 1957 to October 4, 1957 , that I last saw the deceased alive on October 3, 1957 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R.M. McLaughlin | | ADDRESS (Street, city or town, state) DATE SIGNED
BFD 8 Box 442 Pasadena Oct 4, 1957 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/7/57 | 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Tichner & Son | | 24a. REC'D BY REGISTRAR
Oct 8 1957 | 24b. REGISTRAR'S SIGNATURE
L. J. Deakins |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7

BUREAU W. J.

1957 6

RECEIVED

10239

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Patapsco Park | | c. LENGTH OF STAY IN 1b
13 Years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X2 Patapsco Park | | d. STREET ADDRESS
317 Berlin Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle L. Last SCOTT | | 4. DATE OF DEATH
Month October Day 23 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 12, 1889 |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
South Carolina |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Jim Scott | |
| 14. MOTHER'S MAIDEN NAME
Martha Y | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | |
| 16. SOCIAL SECURITY NO.
216-10-4584 | | 17. INFORMANT
Henrietta Scott Address 317 Berlin Avenue | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency
724 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infectious arthritis,
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
3 da
1 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 30 Sept. 57 , to 23 Oct. 57 , that I last saw the deceased alive on 22 Oct. 57 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Renold B. Lighthotter, Jr. M.D. | | DATE SIGNED 501 Cherry Hill Road | |
| PHYSICIAN'S NAME (Type) Renold B. Lighthotter, Jr. M.D. | | Baltimore Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-26-57 | 22c. NAME OF CEMETERY OR CREMATORY
Mt Calvary | 22d. LOCATION (City, town, or county) (State)
Brooklyn Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
ELROY O. WILSON | | ADDRESS
1000 Brantley Avenue | |
| 24a. REC'D BY REGISTRAR
DET 29 57 | | 24b. REGISTRAR'S SIGNATURE
Alfred Smith | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|------------------------------|--|
| 1. NAME OF DECEASED
JAMES H. HARRIS | | 2. SEX
Male | | 3. AGE
65 | |
| 4. RACE
White | | 5. BIRTH DATE
1892 | | 6. BIRTH PLACE
Maryland | |
| 7. DECEASED DATE
1957 | | 8. DECEASED PLACE
Baltimore | | 9. DECEASED TIME
10:00 AM | |
| 10. DECEASED CAUSE
Heart Disease | | 11. DECEASED DISEASE
Coronary Artery Disease | | 12. DECEASED ORGAN
Heart | |
| 13. DECEASED ORGAN
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| 97. DECEASED ORGAN
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| 100. DECEASED ORGAN
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Heart | | 102. DECEASED ORGAN
Heart | |

RECEIVED
OCT 30 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10232

10240

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
1 yr, 4 mos, 19 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Saul Middle (Solomon) Last Scott | | 4. DATE OF DEATH
Month October Day 1 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/12/83 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 4 | 11. IF UNDER 24 HRS.
Hours 4 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Odd Jobs | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James Scott | | 14. MOTHER'S MAIDEN NAME
Anna Green | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
--- | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prolonged Debility DUE TO
(c) --- | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Convulsive Brain Syndrome. Generalized Arteriosclerosis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
about 10 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--- | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. --- p. m. --- 19 --- | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
--- | | 20f. (City or town) (County) (State)
--- | |
| 21. I certify that I attended the deceased from 5/11/56 , 19 56 , to 10/1 , 19 57 , that I last saw the deceased alive on 10/1/57 , 19 --- , and that death occurred at --- M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
L. Benedict, M. D. | | ADDRESS (Street, city or town, state)
Crownsville, Md. DATE SIGNED
10/2/57 | |
| PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/4/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
CHARLES R. LAW | | ADDRESS
802-04 Madison Ave. | |
| 24a. REC'D BY REGISTRAR
OCT 4 1957 | | 24b. REGISTRAR'S SIGNATURE
J. M. Jaynes | |

BUREAU-V. S.

1057 OCT 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10179

CERTIFICATE OF DEATH

10233

Reg. Dist. No.

21

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>U.D.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Emergency Hospital</u> | | d. STREET ADDRESS <u>123 Bayshore Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>LEAH</u> Middle <u>B.</u> Last <u>SEARS</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 12, 1902</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry H. Schamel</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary R. Moore</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>7444</u> | |
| 17. INFORMANT <u>Walter J. Martin</u> Address <u>Hampstead, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u>
330x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u>
DUE TO
(c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10d</u>
<u>15-yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-18-57</u> , 19 <u>57</u> , to <u>10-28-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-28-57</u> , 19 <u>57</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank M. Shipley</u> | | ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>10-29-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> | | <u>Annapolis, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-1-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Freedom</u> | | 22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Wright</u> | | ADDRESS <u>Sykesville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>NOV 1</u> | | 24b. REGISTRAR'S SIGNATURE <u>John J. French</u> | |

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10234

10241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

24

| | | | | | |
|--|------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pasadena
c. LENGTH OF STAY IN 1b
6 months | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Same b. COUNTY Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Same | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bay Side Beach | | | d. STREET ADDRESS
Same | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
John Wilbur Seitz | | | 4. DATE OF DEATH
Month October Day 22 Year 19 57 | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
12/22/07 | | 9. AGE (In years last birthday)
49 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical work | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Adam Seitz | | | |
| 14. MOTHER'S MAIDEN NAME
Margaret Virginia Walters | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Virginia Garlind, (Sister) Address Pasadena, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(c), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | | |
| 20h. (State) | | 20i. (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Gustave H. Faubert M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type)
Gustave H. Faubert M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct 25, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | |
| 22d. LOCATION (City, town, or county)
Baltimore, Maryland | | 22e. (State)
Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lilly & Zeiler Inc., 403 S. Wolfe St. | | 24a. REC'D BY REGISTRAR
DATE 10/23/57 | | 24b. REGISTRAR'S SIGNATURE
L. J. Seelberg | |

RECEIVED

OCT 9 1964

BUREAU V. 2

10242

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Same</u> b. COUNTY <u>Same</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glen Burnie</u> | | c. LENGTH OF STAY IN TB <u>2½</u> years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Same</u> | | d. STREET ADDRESS
<u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>704 Griffith Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Rita Anna Senft</u> | | 4. DATE OF DEATH Month Day Year
<u>October 16th.</u> 19 <u>57</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1/19/20</u> |
| 9. AGE (In years last birthday)
<u>37</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George Grill</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Blecha</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>219-01-6723</u> | |
| 17. INFORMANT
<u>Mr. Walter J Senft (husband)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the liver</u>
<u>156.1</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u> ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>August</u> , 19 <u>57</u> , to <u>October 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 15th.</u> , 19 <u>57</u> , and that death occurred at <u>12.35 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> M.D. <u>Glen Burnie, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>Oct 19-57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Holy Cross</u> | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore A & Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Bernard G. Funic, Glen Burnie Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>10/27/57</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>L. G. Sealtap</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-57

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
[Faint text] | | 2. SEX
[Faint text] | | 3. AGE
[Faint text] | | 4. DATE OF BIRTH
[Faint text] | | 5. PLACE OF BIRTH
[Faint text] | |
| 6. OCCUPATION
[Faint text] | | 7. MARITAL STATUS
[Faint text] | | 8. CAUSE OF DEATH
[Faint text] | | 9. MANNER OF DEATH
[Faint text] | | 10. PLACE OF DEATH
[Faint text] | |
| 11. SIGNATURE OF DECEASED
[Faint text] | | 12. SIGNATURE OF WITNESS
[Faint text] | | 13. SIGNATURE OF PHYSICIAN
[Faint text] | | 14. SIGNATURE OF CORONER
[Faint text] | | 15. SIGNATURE OF JURY
[Faint text] | |
| 16. SIGNATURE OF DECEASED
[Faint text] | | 17. SIGNATURE OF WITNESS
[Faint text] | | 18. SIGNATURE OF PHYSICIAN
[Faint text] | | 19. SIGNATURE OF CORONER
[Faint text] | | 20. SIGNATURE OF JURY
[Faint text] | |
| 21. SIGNATURE OF DECEASED
[Faint text] | | 22. SIGNATURE OF WITNESS
[Faint text] | | 23. SIGNATURE OF PHYSICIAN
[Faint text] | | 24. SIGNATURE OF CORONER
[Faint text] | | 25. SIGNATURE OF JURY
[Faint text] | |
| 26. SIGNATURE OF DECEASED
[Faint text] | | 27. SIGNATURE OF WITNESS
[Faint text] | | 28. SIGNATURE OF PHYSICIAN
[Faint text] | | 29. SIGNATURE OF CORONER
[Faint text] | | 30. SIGNATURE OF JURY
[Faint text] | |
| 31. SIGNATURE OF DECEASED
[Faint text] | | 32. SIGNATURE OF WITNESS
[Faint text] | | 33. SIGNATURE OF PHYSICIAN
[Faint text] | | 34. SIGNATURE OF CORONER
[Faint text] | | 35. SIGNATURE OF JURY
[Faint text] | |
| 36. SIGNATURE OF DECEASED
[Faint text] | | 37. SIGNATURE OF WITNESS
[Faint text] | | 38. SIGNATURE OF PHYSICIAN
[Faint text] | | 39. SIGNATURE OF CORONER
[Faint text] | | 40. SIGNATURE OF JURY
[Faint text] | |
| 41. SIGNATURE OF DECEASED
[Faint text] | | 42. SIGNATURE OF WITNESS
[Faint text] | | 43. SIGNATURE OF PHYSICIAN
[Faint text] | | 44. SIGNATURE OF CORONER
[Faint text] | | 45. SIGNATURE OF JURY
[Faint text] | |
| 46. SIGNATURE OF DECEASED
[Faint text] | | 47. SIGNATURE OF WITNESS
[Faint text] | | 48. SIGNATURE OF PHYSICIAN
[Faint text] | | 49. SIGNATURE OF CORONER
[Faint text] | | 50. SIGNATURE OF JURY
[Faint text] | |
| 51. SIGNATURE OF DECEASED
[Faint text] | | 52. SIGNATURE OF WITNESS
[Faint text] | | 53. SIGNATURE OF PHYSICIAN
[Faint text] | | 54. SIGNATURE OF CORONER
[Faint text] | | 55. SIGNATURE OF JURY
[Faint text] | |
| 56. SIGNATURE OF DECEASED
[Faint text] | | 57. SIGNATURE OF WITNESS
[Faint text] | | 58. SIGNATURE OF PHYSICIAN
[Faint text] | | 59. SIGNATURE OF CORONER
[Faint text] | | 60. SIGNATURE OF JURY
[Faint text] | |
| 61. SIGNATURE OF DECEASED
[Faint text] | | 62. SIGNATURE OF WITNESS
[Faint text] | | 63. SIGNATURE OF PHYSICIAN
[Faint text] | | 64. SIGNATURE OF CORONER
[Faint text] | | 65. SIGNATURE OF JURY
[Faint text] | |
| 66. SIGNATURE OF DECEASED
[Faint text] | | 67. SIGNATURE OF WITNESS
[Faint text] | | 68. SIGNATURE OF PHYSICIAN
[Faint text] | | 69. SIGNATURE OF CORONER
[Faint text] | | 70. SIGNATURE OF JURY
[Faint text] | |
| 71. SIGNATURE OF DECEASED
[Faint text] | | 72. SIGNATURE OF WITNESS
[Faint text] | | 73. SIGNATURE OF PHYSICIAN
[Faint text] | | 74. SIGNATURE OF CORONER
[Faint text] | | 75. SIGNATURE OF JURY
[Faint text] | |
| 76. SIGNATURE OF DECEASED
[Faint text] | | 77. SIGNATURE OF WITNESS
[Faint text] | | 78. SIGNATURE OF PHYSICIAN
[Faint text] | | 79. SIGNATURE OF CORONER
[Faint text] | | 80. SIGNATURE OF JURY
[Faint text] | |
| 81. SIGNATURE OF DECEASED
[Faint text] | | 82. SIGNATURE OF WITNESS
[Faint text] | | 83. SIGNATURE OF PHYSICIAN
[Faint text] | | 84. SIGNATURE OF CORONER
[Faint text] | | 85. SIGNATURE OF JURY
[Faint text] | |
| 86. SIGNATURE OF DECEASED
[Faint text] | | 87. SIGNATURE OF WITNESS
[Faint text] | | 88. SIGNATURE OF PHYSICIAN
[Faint text] | | 89. SIGNATURE OF CORONER
[Faint text] | | 90. SIGNATURE OF JURY
[Faint text] | |
| 91. SIGNATURE OF DECEASED
[Faint text] | | 92. SIGNATURE OF WITNESS
[Faint text] | | 93. SIGNATURE OF PHYSICIAN
[Faint text] | | 94. SIGNATURE OF CORONER
[Faint text] | | 95. SIGNATURE OF JURY
[Faint text] | |
| 96. SIGNATURE OF DECEASED
[Faint text] | | 97. SIGNATURE OF WITNESS
[Faint text] | | 98. SIGNATURE OF PHYSICIAN
[Faint text] | | 99. SIGNATURE OF CORONER
[Faint text] | | 100. SIGNATURE OF JURY
[Faint text] | |

BUREAU Y. 1

OCT 22 1957

RECEIVED

10243

CERTIFICATE OF DEATH

Reg. Dist. No.

25

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. CO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>a.a.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BROOKLYN MD</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>303 ANDREY AVE</u> | | | | d. STREET ADDRESS
<u>1303 ANDREY AVE</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>WILLIAM</u> Middle <u>F.</u> Last <u>SIMMONT</u> | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>21</u> Year <u>1957</u> | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1/25/1890</u> | |
| 9. AGE (In years last birthday)
<u>67</u> yrs. | | IF UNDER 1 YEAR
Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u> | | IF UNDER 24 HRS.
Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SLP. MATTHESON CHEMICAL CO</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>BALTO MD</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>BALTO MD</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>MD</u> | | | |
| 13. FATHER'S NAME
<u>HARRY T. SIMMONT</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY BOSMAN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>(If yes, give war or dates of service)</u> | | | | 16. SOCIAL SECURITY NO.
<u>ADDIE M. SIMMONT 303 ANDREY AVE</u> | | | |
| 17. INFORMANT
<u>ADDIE M. SIMMONT 303 ANDREY AVE</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>
260x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u>
(c) <u>Diabetes</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>10</u> a. m. <u>20</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
<u>BALTIMORE</u> | | | | 20g. (County)
<u>MD</u> | | 20h. (State)
<u>MD</u> | |
| 21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>55</u> , to <u>Oct 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Samuel Rubin</u> M.D. | | | | ADDRESS (Street, city or town, state)
<u>203 Butafresco Ave</u> | | | |
| DATE SIGNED
<u>10/24/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>Samuel Rubin</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>10/24/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>SACRED HEART</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTIMORE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Clarence F. Hoffmann</u> | | | | ADDRESS
<u>3218 Hudson St</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 23 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Ida Wilson</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO. 100

MARYLAND

BUREAU V. 3

OCT 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6,7 Film G221 10-15-57 et

CERTIFICATE OF DEATH

10244

10237

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>AA</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Millersville Md</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Severna Park</u> x2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Sands Nursing Home</u> | | | | d. STREET ADDRESS
<u>Md</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Charles</u> Middle <u>H.</u> Last <u>Smith</u> | | | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>8</u> Year <u>1957</u> | | | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 10, 1873</u> | | 9. AGE (In years last birthday)
<u>84</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Railroad man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Rail Road</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Balto Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Augustus Smith</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
<u>Son - Severna Park</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u>
DUE TO <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1956</u> , to <u>1957</u> , that I last saw the deceased alive on <u>10-4-57</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Robert B. Hahn</u> M.D. | | | | ADDRESS (Street, city or town, state)
<u>Severna Park Md.</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Robert B. Hahn</u> | | | | DATE SIGNED
<u>10-8-57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
<u>Oct. 11, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Shen Haven</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Shen Burnie Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>P. Singleton</u> | | | | ADDRESS
<u>Shen Burnie Md.</u> | | 24a. REC'D BY REGISTRAR
<u>10-10-57</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Mathew Joyce</u> | |

CERTIFICATE OF DEATH

BUREAU V. H.

OCT 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10238

10245

CERTIFICATE OF DEATH

Reg. Dist. No.

28

| | | | | |
|--|----------------------------------|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Washington, D.C. b. COUNTY Baltimore City | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville, Md. | | c. LENGTH OF STAY IN 1b
few hours | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Will Middle Elbert Last Sneed | | 4. DATE OF DEATH
Month 10 Day 16 Year 19 57 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-7-1893 AGE (In years last birthday) 64 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
Sam Sneed | | 14. MOTHER'S MAIDEN NAME
Jeannie | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | | |
| 17. INFORMANT
Hospital Records | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis
DUE TO (c) Senility | | | | INTERVAL BETWEEN ONSET AND DEATH
few hours
" " |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from October 16, 1957 , to October 16, 1957 , that I last saw the deceased alive on October 16, 1957 , and that death occurred at 9:40 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED | | | | |
| ACTUAL SIGNATURE L. Benedict | | M.D. Crownsville, Md. | | |
| PHYSICIAN'S NAME (Type) L. Benedict, M. D. | | Crownsville State Hospital, Md. | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-21-57 | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Woods Grove Cem | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Clara D. Sively | | 24a. REC'D BY REGISTRAR
18 1957 | | |
| ADDRESS
661 W. Borne | | 24b. REGISTRAR'S SIGNATURE
A. M. Joyce | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. 011-10

DATE OF DEATH
2 OCTOBER 1957

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

BUREAU V. S.

OCT 18 1957

RECEIVED

10246

CERTIFICATE OF DEATH

Reg. Dist. No.

28

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Annapolis</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Annapolis</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville Maryland</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Agnes General Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Carol Sparrows</i> | | | | 4. DATE OF DEATH <i>10-15-57</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>Colonial</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>4-11-1952</i> | |
| 9. AGE (In years last birthday) <i>5</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <i>None</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Paul Sparrows</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Dorothy Belt</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give branch known) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>Paul Sparrows</i> Address <i>Millersville Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Leukemia</i>
<i>204.3</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <i>approx. 1 day</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10-15, 1957</i> to <i>10-15, 1957</i> , that I last saw the deceased alive on <i>10-15, 1957</i> , and that death occurred at <i>10:45 PM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Faye W. Allen</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>62 Cathedral St.</i> DATE SIGNED <i>10-18-57</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Faye W. Allen</i> | | | | ADDRESS <i>62 Cathedral St.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 22b. DATE THEREOF <i>10-21-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Elkridge</i> | | 22d. LOCATION (City, town, or county) (State) <i>Elkridge, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i> ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE <i>10/22/57</i> | | 24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. [Signature]

Dr. [Signature]

Dr. [Signature]

BUREAU V. S.

OCT 23 1957

RECEIVED

William [Signature] - [Signature] 10-21-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10240

10247

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A.A. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Orchard Beach | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Orchard Beach | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1214 Riverside Drive | | d. STREET ADDRESS
1214 Riverside Dr. | |
| 3. NAME OF DECEASED (Type or print)
First HARRY A. SPECHT Middle Last | | 4. DATE OF DEATH
10/9/57 Month Day Year | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/8/17 |
| 9. AGE (In years last birthday)
40 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Pa. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Harry H. | | 14. MOTHER'S MAIDEN NAME
Sarah Pope | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Family - Same | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardio-vascular disease DUE TO
1 year
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myxedema - 10 yrs. duration. Cyst of the thyroid gland
10 years duration. Ant abdominal hernia 10 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 1, 1950 , to October 9, 1957 , that I last saw the deceased alive on October 7, 1957 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
R.M. McLaughlin M.D. P.O. Box 447, Pasadena, Md. Oct. 9, 1957
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) R.M. McLaughlin, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
B | | 22b. DATE THEREOF
10/12/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 22d. LOCATION (City, town, or county) (State)
Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
McCully Funeral Homes - 130 E. Fort Ave. | | 24. REC'D BY REGISTRAR
DATE 11 1957 | |
| 24b. REGISTRAR'S SIGNATURE
L. J. DeLap | | | |

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED
 [Faint text]</p> | | <p>2. SEX
 [Faint text]</p> | |
| <p>3. AGE
 [Faint text]</p> | | <p>4. DATE OF BIRTH
 [Faint text]</p> | |
| <p>5. PLACE OF BIRTH
 [Faint text]</p> | | <p>6. OCCUPATION
 [Faint text]</p> | |
| <p>7. MARITAL STATUS
 [Faint text]</p> | | <p>8. CAUSE OF DEATH
 [Faint text]</p> | |
| <p>9. PLACE OF DEATH
 [Faint text]</p> | | <p>10. DATE OF DEATH
 [Faint text]</p> | |
| <p>11. SIGNATURE OF PHYSICIAN
 [Faint text]</p> | | <p>12. SIGNATURE OF REGISTRAR
 [Faint text]</p> | |
| <p>13. SIGNATURE OF WITNESS
 [Faint text]</p> | | <p>14. SIGNATURE OF DECEASED
 [Faint text]</p> | |

BUREAU V. 1

OCT 11 1957

RECEIVED

10180

CERTIFICATE OF DEATH

10241

Reg. Dist. No.

21

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A. A. County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md. 10</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hospital</u> | | | | d. STREET ADDRESS <u>135 West St.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mabel E. Spriggs</u> | | | | 4. DATE OF DEATH <u>10-11-1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Caucasian</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-2-1897</u> | |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mrs. J. E. Spriggs</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William Brashears</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Queen</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>7-10-100000</u> | | | |
| 17. INFORMANT <u>Stephen Spriggs</u> | | | | Address <u>Annapolis, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage of left 5 hours</u>
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic hypertensive cardiac</u>
DUE TO (c) <u>vascular disease</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 hours</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>10/10/57</u> , 19 <u>57</u> , to <u>10/11/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/11/57</u> , 19 <u>57</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> | | | | ADDRESS (Street, city or town, state) <u>110 CLAY STREET</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Wm. H. Polk, M.D.</u> | | | | DATE SIGNED <u>10/11/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-15-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u> | | | | ADDRESS <u>110 CLAY STREET</u> | | | |
| 24a. REC'D BY REGISTRAR <u>Wm. J. Funch</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Funch</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

10248

10248

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10242

Reg. Dist. No.

| | | | | | |
|--|-------------------------------|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HA Co</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>GA Co</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Haven</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Jesse L. Lawrence Stants</u> | | 4. DATE OF DEATH <u>OCT 30 1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 28-1902</u> | | |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>30</u> Hours <u>19</u> Min. <u>57</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>West Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Jesse L. Stants</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Kremer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Bertha Stants</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u>
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u>
(c) <u>None</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Feb. 19</u> , 19 <u>55</u> , to <u>October 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 29</u> , 19 <u>57</u> , and that death occurred at <u>1:05 P.</u> M., from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>R. M. McLaughlin</u> | | ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u> | | DATE SIGNED <u>Oct. 31, 1957</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov 2-57</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Frank</u> | | 24a. REC'D BY REGISTRAR <u>W. I. 1957</u> | | | |
| ADDRESS <u>4444 Rte 1</u> | | 24b. REGISTRAR'S SIGNATURE <u>Louis DeAlba</u> | | | |

ES

CERTIFICATE OF DEATH

BUREAU V. 2

NOV 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10243

10249

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|--|--|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jessups | | | c. LENGTH OF STAY IN 1b
20 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Jessups | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1 | | | | d. STREET ADDRESS
1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Sophia Middle Alice Last Steiner | | | | 4. DATE OF DEATH
Month Oct. Day 12 Year 1957 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 22, 1875 | | |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
George W. Shoemaker | | | | 14. MOTHER'S MAIDEN NAME
Sarah H. Eyler | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
David Steiner | | Address
Jessups, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
443x IMMEDIATE CAUSE (a) Hypertensive Cardio-Vas.
DUE TO Disease with Cardiac Congestion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO (b) _____
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 wks.
2 wks. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from Dec. 56 Oct. 12 , 19 57 to Oct. 12 , 19 57 , and that death occurred on Oct. 12 , 19 57 , at 8:20 A.M. , from the causes and on the date stated above.
ACTUAL SIGNATURE Frank E. Shipley M.D. Savage, Md. 10-13-57
PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 16, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frederick, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C.E. Cloutier | | | | 24a. REC'D BY REGISTRAR
15 Oct 1957 | | 24b. REGISTRAR'S SIGNATURE
Clara H. Hays | | |
| 8 E. Patrick St., Frederick | | | | | | | | |

* 21V QS

Topic

EVALUATION OF THE...

* . 000000

BUREAU V. S.

OCT 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10244

10250

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A.A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riviera Beach | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riviera Beach | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Main Drive & Meadow Rd. | | | | d. STREET ADDRESS
Main Drive & Meadow Rd. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
LILLIAN M. STINDT First Middle Last | | | | 4. DATE OF DEATH
Month 10 Day 14 Year 57 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/25/83 | 9. AGE (In years last birthday)
73 yrs | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
? Rhoades | | | | 14. MOTHER'S MAIDEN NAME
Mary ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT
Family - Same | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
420.1 IMMEDIATE CAUSE (a) Acute coronary thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO
INTERVAL BETWEEN ONSET AND DEATH
12 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from October 14, 1957 , to October 14, 1957 , that I last saw the deceased alive on October 14, 1957 , and that death occurred at 7:30 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
R. M. McLaughlin | | ADDRESS (Street, city or town, state)
BEDS 6442 Pasadena, Md. | | DATE SIGNED
Oct 14 1957 | | | |
| PHYSICIAN'S NAME (Type)
R. M. McLaughlin | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
B | 22b. DATE THEREOF
10/17/57 | 22c. NAME OF CEMETERY OR CREMATORY
Holy Cross | 22d. LOCATION (City, town, or county)
Baltimore | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
McCully Funeral Homes - 130 E. Fort Ave. | | ADDRESS
130 E. Fort Ave. | | 24a. REC'D BY REGISTRAR
OCT 16 1957 | 24b. REGISTRAR'S SIGNATURE
J. Schell | | |

CERTIFICATE OF DEATH

Page 1000

| | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|----------------|--|-----------------|--|--------------------|--|---------------------|--|----------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Manner of Death | | Cause of Death | | Place of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | New York | | Natural | | Heart Disease | | Home | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | |
| Occupation | | Marital Status | | Education | | Religion | | Previous Illnesses | | Alcohol Consumption | | Tobacco Use | | Drugs | | Injury | | Signature of Informant | | Signature of Registrar | |
| Teacher | | Married | | High School | | Catholic | | None | | Occasional | | Occasional | | None | | None | | J. Doe | | J. Doe | |
| Date of Death | | Time of Death | | Place of Death | | Manner of Death | | Cause of Death | | Place of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Registrar | |
| Oct 15, 1957 | | 10:00 AM | | Home | | Natural | | Heart Disease | | Home | | 10:00 AM | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe | | J. Doe | |

BUREAU V. 2

OCT 16 1957

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The form copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 14 FilmG221 10-17-57 et

CERTIFICATE OF DEATH

10245

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY AA | MARYLAND | STATE Maryland | COUNTY AA |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Bar Harbor | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Bar Harbor | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
Sylvia F. Stokes | | 4. DATE OF DEATH (Month) (Day) (Year)
10 10 19 57 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
5/14/06 |
| 9. AGE last birthday
51 yrs. | | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)
10 10 19 57 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Walter A. Geary | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS
Family Same | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 171X IMMEDIATE CAUSE (A)
Terminal Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. | | Cancer of the cervix of uterus about 4 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from June 18, 1957 , to October 8, 1957 , that I last saw the deceased alive on Oct 8, 1957 , and that death occurred at 6:10 A.M. from the causes and on the date stated above. | | | |
| SIGNATURE
Helen P. Neelock | | DATE SIGNED
Oct 10, 1957 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEROF
10/12/57 | |
| NAME OF CEMETERY OR CREMATORY
Zion Lutheran Cem. | | LOCATION (City, town, or county) (State)
Stemmers Run, Md. | |
| 24. REC'D BY REGISTRAR
OCT 14 1957 | | 25. FUNERAL DIRECTOR'S SIGNATURE
McCully Funeral Homes 130 E. Fort Ave. | |

CERTIFICATE OF DEATH

Reg. No. 14

1. USING A REGISTERED HOUSE OF CHURCH

NAME AND

DATE OF BIRTH

AGE

SEX

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

2. MEDICAL CERTIFICATION

BUREAU V. S.

OCT 14 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

21

10181

FOR STATE
HEALTH DEPT.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>WASH. DC</u> b. COUNTY <u>47X-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ANNAPOLIS</u> | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>A.A. Hosp.</u> | | d. STREET ADDRESS
<u>322 Prospect St - NW</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>ADELBERT G. Thompson</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>17</u> Year <u>1957</u> | 5. RESIDENCE ON A FARM
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JULY 25, 1890</u> |
| 9. AGE (In years last birthday)
<u>67</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>6</u> Days <u>17</u> | 11. IF UNDER 24 HRS.
Hours <u>10</u> Min. <u>17</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MOTORMAN - Retired A.C. Transit</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Vo.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John H. Thompson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Dawson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>578-10-7481</u> | |
| 17. INFORMANT
<u>John A. Thompson, Son.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Disease</u>
<u>434.3</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>19</u> a. m. <u>19</u> p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>E. Linhart</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>E. Linhart</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>10/22/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Ft. Myer, Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W.W. Chambers Co., Wash, D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>21 1957</u> | |
| | | 24b. REGISTRAR'S SIGNATURE
<u>Am J French</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10247

10252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ferndale
c. LENGTH OF STAY IN 1b
10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3 Ferndale Avenue | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Same
b. COUNTY
Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X 2 Same
d. STREET ADDRESS
1 Same
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
1st/1st Raleigh I. Timson
First Middle Last | | | 4. DATE OF DEATH
October 24th. 19 57
Month Day Year | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
5/14/87 | | 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country)
Brattleboro, Vermont. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Richard H. Timson | | | 14. MOTHER'S MAIDEN NAME
Nannie Carter | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Self inflicted wound to the brain with a 32 gauge revolver.
DUE TO (b) 976x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
Shot himself in the right temple. (32 gauge revolver) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
7.05 a.m. 10/24/57 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| 20f. (City or town)
Ferndale | | 20g. (County)
A.A. | | 20h. (State)
Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Gustave H. Faubert | | M.D.
Gustave H. Faubert, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/24/57
DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/28/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | |
| 22d. LOCATION (City, town, or county)
Woodlawn, Md. | | (State)
Md. | | 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Dickner & Sons - Balt. 17, Md. | |
| 24a. REC'D BY REGISTRAR
10/28/57 | | DATE
10/28/57 | | 24b. REGISTRAR'S SIGNATURE
L. G. Deally | |

STATE DEPARTMENT OF HEALTH - BATHING

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-2-2

FOR STATE
HEALTH DEPT.

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

BUREAU V. 3.

OCT 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10248

10253

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE | | c. LENGTH OF STAY IN 1b 4 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SANN'S NURSING HOME | | d. STREET ADDRESS MT. PLEASANT BEACH | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle SMITH Last TYLER | | 4. DATE OF DEATH
Month OCT. Day 13 Year 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 19, 1871 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WATERMAN | | 10b. KIND OF BUSINESS OR INDUSTRY SHIPPING | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME OLIVER B. TYLER | | 14. MOTHER'S MAIDEN NAME MARTHA HEWITT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 218-09-0184 | |
| 17. INFORMANT MRS. JOHN SCHMIDT | | Address PASADENA, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CAACINOMA BLADDER
181X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JULY , 19 56 , to OCT. 13 , 19 57 , that I last saw the deceased alive on OCT. 9 , 19 57 , and that death occurred at 11:40 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Brady Smith | | ADDRESS (Street, city or town, state) RIVIERA BEACH, MD. | |
| PHYSICIAN'S NAME (Type) J. BRADY SMITH | | DATE SIGNED 10/13/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-16-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY TARSONS | | 22d. LOCATION (City, town, or county) (State) SALISBURY MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwal | | 24a. REC'D BY REGISTRAR DATE 15 1957 | |
| 24b. REGISTRAR'S SIGNATURE J. M. Joyce | | | |

BUREAU V. 3

OCT 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10183
CERTIFICATE OF DEATH

10250

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u> | | d. STREET ADDRESS <u>909 1/2 West St.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Ray</u> Last <u>Whitaker</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 3, 1952</u> |
| 9. AGE (In years last birthday) <u>5</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>19</u> Min. <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Luther Whitaker</u> | | 14. MOTHER'S MAIDEN NAME <u>Betty Greer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Luther Whitaker</u> Address <u>#2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden C.N.S. & vascular collapse</u>
917.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stress w. Th febrile reaction</u>
DUE TO (c) <u>Burns superficial, 1st & 2nd degree, face & chest</u>
INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>
<u>4 1/2 hrs.</u>
<u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None known or apparent</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Home accident - baby tipped over cup hot water, scalding self</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>12:30 p.m. 10-14 1957</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>AB</u> (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct. 14, 1957</u> , to <u>Oct. 15, 1957</u> , that I last saw the deceased alive on <u>Oct. 15, 1957</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Merton T. Waite</u> | | M.D. <u>Cathedral & Dean St. Annapolis Md 10-15-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Merton T. Waite, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>10-16-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Abington</u> | | 22d. LOCATION (City, town, or county) (State) <u>Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Layla & Son Annapolis, Md.</u> | | ADDRESS <u>10/16/57</u> | |
| 24a. REC'D BY REGISTRAR <u>10/16/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>V. Ornel</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10-2-57

10-2-57

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
[Faint text] | | 2. SEX
[Faint text] | | 3. AGE
[Faint text] | | 4. DATE OF BIRTH
[Faint text] | |
| 5. PLACE OF BIRTH
[Faint text] | | 6. OCCUPATION
[Faint text] | | 7. MARITAL STATUS
[Faint text] | | 8. EDUCATION
[Faint text] | |
| 9. CAUSE OF DEATH
[Faint text] | | 10. MANNER OF DEATH
[Faint text] | | 11. PLACE OF DEATH
[Faint text] | | 12. TIME OF DEATH
[Faint text] | |
| 13. SIGNATURE OF PHYSICIAN
[Faint text] | | 14. SIGNATURE OF REGISTRAR
[Faint text] | | 15. SIGNATURE OF WITNESS
[Faint text] | | 16. SIGNATURE OF DECEASED
[Faint text] | |
| 17. SIGNATURE OF DECEASED
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| 21. SIGNATURE OF DECEASED
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| 33. SIGNATURE OF DECEASED
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| 57. SIGNATURE OF DECEASED
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| 61. SIGNATURE OF DECEASED
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| 81. SIGNATURE OF DECEASED
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| 85. SIGNATURE OF DECEASED
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| 89. SIGNATURE OF DECEASED
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| 93. SIGNATURE OF DECEASED
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| 97. SIGNATURE OF DECEASED
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[Faint text] | | 99. SIGNATURE OF DECEASED
[Faint text] | | 100. SIGNATURE OF DECEASED
[Faint text] | |

BUREAU V. 3

OCT 18 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10251

CERTIFICATE OF DEATH

Reg. Dist. No. 24

10254

| | | | | | | | |
|--|---------------------------|--|-----------------------------------|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH
COUNTY <u>ANNE ARUNDEL</u> MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Green Bayside</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Playa Manos Convent Home</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>Maryland</u> COUNTY <u>C.A.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Jones Station</u>
STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ALICE WHITTINGTON</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 15 1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid.</u> | 8. DATE OF BIRTH <u>6-29-1884</u> | 9. AGE last birthday <u>73</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maids</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>But. family</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Gambrell</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Susan Bond</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT & ADDRESS <u>Isabel Watts - Anna, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
<u>447X IMMEDIATE CAUSE (A) Hypertensive vascular disease</u>
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 1957</u> , to <u>Oct 15, 1957</u> , that I last saw the deceased alive on <u>Oct 12, 1957</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Joseph Taler</u> | | M.D. <u>102 Bd A Blvd. N.E. Green Bayside, Md.</u> | | DATE SIGNED <u>10-16-57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>10-20-57</u> | | NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u> | | LOCATION (City, town, or county) (State) <u>Green Bay, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>10/27/57</u> | | REGISTRAR'S SIGNATURE <u>L. J. Seabury</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> | | ADDRESS | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

TO BE FILLED BY THE REGISTRAR OF VITAL RECORDS

TO BE FILLED BY THE REGISTRAR OF VITAL RECORDS

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DIVORCE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

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DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

BUREAU V. S.

101 23 1957

RECEIVED

Handwritten signature and date: 10-20-57

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10255

10255

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10252
Reg. Dist. No. 27

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mississippi b. COUNTY Yazoo | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort George G. Meade | | c. LENGTH OF STAY IN 1b
3 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Army Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Willie Middle V Last Williams | | 4. DATE OF DEATH
Month October Day 3 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
30 September 57 |
| 9. AGE (In years last birthday) yrs. 3 | | 10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Wilbert Lee Williams | | 14. MOTHER'S MAIDEN NAME
Georgia Lue Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Father, 104 King Court, Dundalk, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity Prematurity
776X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. ft. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 30 Sep , 19 57 , to 3 Oct , 19 57 , that I last saw the deceased alive on 3 Oct 57 , 19 57 , and that death occurred at 1:45 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Fort G. G. Meade, Md. DATE SIGNED 3 Oct 57 | | | |
| ACTUAL SIGNATURE Frank L. Gruskay | | M.D. USA | |
| PHYSICIAN'S NAME (Type) FRANK L. GRUSKAY, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct-7-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, county) (State) Frederick Road, Baltimore, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Wolter | | 24a. REC'D BY REGISTRAR Wilbur H. Downs, Jr., Capt. MSC | |
| ADDRESS Funeral Home | | DATE 3 Oct 57 | |

6306 Belair Rd Baltimore 6 - Md 2050326XVI

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G221 10-18-57 et

CERTIFICATE OF DEATH

10256

10254

Reg. Dist. No.

| | | | |
|---|------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE, Md. | | c. LENGTH OF STAY IN 1b 2 yrs, 5 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WALTER Middle WILSON Last WILSON | | 4. DATE OF DEATH Month Oct. Day 5 Year 1957 | |
| 5. SEX M | 6. COLOR OR RACE Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Unknown |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME EDWARD WILSON | | 14. MOTHER'S MAIDEN NAME Adeline | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE
260x DUE TO ACUTE + CHRONIC PIELONEPHRITIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS
(c) 2 mos -
2 yrs - | | INTERVAL BETWEEN ONSET AND DEATH Few hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. — 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 6, 1955 to Oct 5, 1957 , that I last saw the deceased alive on Oct. 5, 1957 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Conwell Newton M.D. | | ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED 10.5.57 | |
| PHYSICIAN'S NAME (Type) CONWELL NEWTON | | | |
| 22a. BURIAL-CREMAATION-REMOVAL (Specify) 10-10-57 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 Wash. St. Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 14 1957 | |
| 24b. REGISTRAR'S SIGNATURE A. M. Joyce | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 5

OCT 15 1957

RECEIVED

10184

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Mo.</u> b. COUNTY <u>A.A.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>A.A. General Hospital</u> | | d. STREET ADDRESS
<u>1 Edgewater</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Florine</u> Middle <u>Wood</u> Last <u>Wood</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>3</u> Year <u>1957</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-2-1957</u> |
| 9. AGE (In years last birthday)
<u>1</u> yrs. | | IF UNDER 1 YEAR
Months <u>1</u> | IF UNDER 24 HRS.
Hours <u>1</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Alvin C. Wood</u> | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Ours</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Alvin C. Wood</u> | |
| 17. INFORMANT
<u>Alvin C. Wood</u> | | Address
<u>#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>763.0</u> DUE TO <u>pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 day</u>
DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u>
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>57</u> , to <u>Oct 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>57</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>Neil H. Sims</u> M.D.
PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>10-5-57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>LEADAR BAPTIST</u> | 22d. LOCATION (City, town, or county) (State)
<u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Taylor Sons Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>10/4/57</u> | 24b. REGISTRAR'S SIGNATURE
<u>V. O. ...</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063306XV5

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

OCT 7 1967

RECEIVED